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ABSTRACT

The findings and recommendations of the Temporary State Commission to Evaluate the Drug Laws, set forth in the introduction to this report, are based on questionnaires to prevention experts and professionals responsible for child and adolescent care, on communications with community agencies, and on statewide public hearings. The committee found that few positive results could be ascertained for the State's programs, that use of cocaine and alcohol have rapidly increased among the young, that the immediate cause of drug abuse is poor self esteem, and that funding for drug abuse programs should be redirected toward learning, health, and emotional problems. Chapters on the drug situation in New York State and on concepts in drug abuse prevention open the explication of the committee's findings. Recommendations in the areas of education and health, delivery of community health and mental health services to children and families, the media, and alternatives to drug abuse programs are enlarged on in separate chapters of the report. Commission bills to establish a New York State Driving Under the Influence of Alcohol Countermeasure Program and to redefine prevention of drug and alcohol abuse are appended along with a list of 1973 hearing witnesses. (JH)

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Drug Abuse Prevention

Report of the Temporary State Commission To Evaluate the Drug Laws

**Assemblyman Emeel S. Betros,
Chairman**

SO 007 600

JUN 13 1974

LETTER OF TRANSMITTAL

To The Governor and The Legislature of The State of New York:

Pursuant to Chapter 474 of the Laws of 1970, as amended in 1973, the Temporary State Commission to Evaluate the Drug Laws hereby respectfully submits the following report.

Assemblyman Emeel S. Betros, Chairman

Judge Irving Lang, Vice Chairman

Senator Robert Garcia, Secretary

Henry Brill, M.D.

Senator John R. Dunne

Senator Joseph L. Galiber

Assemblyman Chester R. Hardt

Assemblyman Alan G. Hevesi

Senator Tarky Lombardi, Jr.

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ACKNOWLEDGEMENT

On behalf of the Commission, I wish to express our appreciation to Assembly Speaker Perry B. Duryea, for encouraging the development in our state of more fruitful concepts of the prevention of the abuse of chemical substances, and to Assemblyman Vincent Riccio, Chairman of the Assembly Health Committee Subcommittee on Narcotic Drugs, for joining with us in holding public hearings on this topic and for sharing with us his experience and considerable talents in this field.

EMEEL S. BETROS
Chairman

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INTRODUCTION; FINDINGS AND RECOMMENDATIONS

Prior to the 1973 session of the Legislature, the Assembly Health Committee Subcommittee on Narcotic Drugs launched a series of statewide hearings on the subject of the effectiveness of drug abuse prevention programs. The subcommittee received a great deal of testimony relating to the inefficiency of the administration of such programs, and, especially, testimony requesting a two-to-three-year funding pattern, rather than the present one-year pattern.

The Chairman of the subcommittee and the Chairman of the full Assembly Health Committee, as well as the incoming Chairman of this Commission, were concerned that these hearings did not explore in sufficient depth the fundamental validity of the concepts of prevention, and the relationship between a variety of forms of chemical substance abuse, such as the use of alcohol among the young, as a drug by itself, and in the context of other depressant abuse.

The three Chairmen therefore resolved to widen the subject matter under study to ascertain whether beyond the concepts of treatment, of regulation of the manufacture and dispensing of therapeutic mood-altering drugs, and of vigorous law enforcement, there really were fruitful methods being used throughout the state and nation to deter serious abuse of chemical substances.

The Commission began its inquiries with two series of questionnaires: one to so-called prevention experts, and another to professionals responsible for child and adolescent care who were not specifically identified as "drug experts". Over four hundred responses were received. As we had anticipated, the vast majority of child care professionals were far more interested in the underlying causes of drug abuse and alcoholism than they were in attempting to steer children away from the particular symptom. They did not believe that society could genuinely deter drug abuse through current efforts, but even if it could, they predicted that without addressing underlying problems there would be a continual shifting of symptoms: now depressants, now stimulants, now alcohol, now violence, now promiscuity, and now combinations of these as well as other forms of aberrent conduct. A surprising number of drug abuse prevention experts agreed. Although they call for increased funding of their particular programs, they readily admit that they are powerless to deal with the fundamental social problems which cause young people to continue to behave with symptomatic self-destructive tendencies in larger numbers than ever before.

On the basis of responses to our questionnaires the Commission opened lines of communication with numerous community agencies, both public and private, intensified its research activities, and scheduled six new public hearings, jointly with the subcommittee, for the purpose of receiving further information from which to evaluate state policies regarding both drug abuse prevention, per se, and the adequacy of other efforts to deal with underlying causes of problems among young people in this state. The six hearings were well attended by invited guests, by state officials, by representatives of community organizations, including drug programs, and by the general public. The hearings were held in Albany on October 10, 1973; in New York City on October 18th, in Buffalo on October 24th, in Poughkeepsie on November 8th, in Syracuse on November 20th and in Hauppauge, Long Island, on November 28th.

FINDINGS AND RECOMMENDATIONS

1. An assessment of the entire range of information made available to this Commission during the past year of study leads to one inescapable conclusion: Of the approximately $167,000,000 spent each year for drug programs in this state, few positive results can be ascertained for the more than $23,000,000 usually allocated through the Youthful Drug Abuse program for prevention and drug education efforts.

2. We find that although narcotics arrests have decreased in New York state, the use of cocaine and alcohol have rapidly increased among the young. Particularly in the counties of Onondaga, Nassau and Suffolk, and in the inner-cities of Buffalo, Rochester and New York City, we found alcohol use among young people from ages 15 to 25 to be approaching epidemic proportions. In many areas of the state, heavy marihuana, barbiturate and methaqualone use continue to be a problem. Recently, Librium and Valium have joined these other drugs as currency in illicit street traffic. Adult abuse of stimulants and depressants is beginning to surface with the enforcement of tighter restrictions on the prescribing and dispensing of these substances. Youthful illicit manufacture of hallucinogenic substances also continues, coupled with fraudulent

sales of phencyclidine and industrial chemicals as bogus LSD and THC.

3. We find that the immediate cause of substance abuse is poor self-esteem among the young. We believe that in most cases, young people who are likely to engage in deviant behavior, particularly substance abuse, have been started upon a continuum to failure from their earliest years. Conditioned by living in neighborhoods with poor housing, unemployment, and inaccessible family services, health and mental health care, their concrete problems are compounded by numerous educational impediments. Such youngsters may abandon the system at any point to become destructive or self-destructive rather than productive members of society. We find that a child who has been short-changed educationally cannot have very much respect for his mind. We find that a child whose health has not been properly attended cannot have very much respect for his body. Poor self-esteem may also be found among affluent youngsters whose families are beset by more abstract problems, because such youngsters do not learn satisfactory coping mechanisms from their parents. The clearest examples of this we have found to be in families in which the use of alcohol or prescribed psychoactive drugs among parents to solve problems which seem overwhelming is mirrored by heavy illicit drug and alcohol abuse among their children.

4. We find that the changing and continuing needs of our children in this state are so profound, that a substantial portion of the funding presently aimed at drug abuse prevention should be redirected towards aiding children with learning problems, children with health problems and children with emotional problems.

We find that children with learning problems are subject to a staggering degree of frustration, both within the educational world and in their social lives. There is much data to support the belief that children with learning problems, which have not been corrected or compensated for earlier in their schooling, have a higher rate of school dropouts than other children.

Emotional problems resulting from the frustrations caused by learning disabilities place these children in a higher risk category, not only with respect to school dropouts, but also with respect to drug abuse, alcoholism and other forms of anti-social behavior. More than two-thirds of the learning disabilities specialists recently surveyed responded that among non-seriously handicapped children with learning disabilities drug experimentation was prevalent.

Education and Health

We make the following recommendations, which are more fully explained in our chapter on education:

1. We find that the continuum to failure, which lowers the self-esteem of young people, and ultimately causes them to be unemployable and to engage in a variety of modes of destructive and self-destructive conduct, including substance abuse, begins with a variety of conditions, the effects of which can be effectively arrested and remedied in the school system. Four techniques appear to hold the greatest promise in this regard:

a. We find that the learning process can often be aided by scaling the educational unit down to a manageable size, as exemplified by the mini-schools. The proviso we offer, however, is that improving the scholastic achievement of the individual student must be the goal, rather than stimulation of interest and increased contact with staff, without specific attempts to develop increased academic skills.

b. We find that health screening, particularly with regard to conditions directly affecting learning, such as perception, should be available to all students, regardless of income. Actual treatment of diagnosed conditions should be provided on the basis of need; however, detection of learning impediments is so often overlooked by parents and teachers, even with regard to middle-class and near-indigent children, that these services should simply be available to all in the same way that public education, itself, is available to all. We see little purpose in demanding that the state teach children to read, write and calculate, when hundreds of thousands of them are unable to do as well as their natural endowments would permit, because of learning disabilities, short of gross handicaps, that go undetected until the child becomes involved in a serious behavioral difficulty. We strongly urge the implementation throughout the state of the screening techniques used by the N.Y.U. Learning Disorders Unit at P.S.116, and, to the extent practicable, within the framework of community provision of health care, we support school-based diagnosis under the program of early and periodic screening of children.

c. We find that the key to continuing good health practices among school-age children, the essence and core of their respect for the integrity of their own physical well-being, and a substantial preventive to substance abuse, is the availability of competent school nurse-teachers, health aides and assistants in the schools and as liaisons between school, home and providers of community health care. We find a severe lack of such personnel and, therefore, we recommend substantial increases in their numbers. We further recommend as a goal, no greater responsibility than 300 students per each school nurse with one assistant.

d. We find that competent guidance counselors are not free to help students and families deal with learning difficulties which result from personal problems, adjustment difficulties and unclear career choices, because of the sheer case-load burden of each counselor. We admire the efforts of the street-workers at Haaren to help students in this regard, but we believe that the state should provide more fully trained counselors in the schools, with greatly reduced responsibilities, not to exceed 150 students per counselor. No child in the State of New York should have to take drugs or become intoxicated with alcohol in order to have attention paid to his personal or family problems.

2. While we view counselor confidentiality as an incident of personal discretion, based upon the relationship between counselor and student, rather than as a legal right to be protected by statute, we also view the medical records of students as sacrosanct: In the event that greater efforts are to be made in the schools to diagnose health problems, the need for well-kept records, inviolate to discipline authorities, must be recognized.

3. We find that the causes of substance abuse are not related to a paucity of information among the young about drugs and alcohol. Consequently, we find that sections 804, 804-a and 805 of the education law mandating instruction in the harmful effects of alcohol and drugs are totally counterproductive. To the extent that such instruction is informative, it stimulates unnecessary interest in the subject matter and may promote experimentation. To the extent that such instruction is unclear regarding appropriate

social values, which we find is often the case despite the misleading caption of "values clarification" instruction, such instruction may directly, if unwittingly, induce experimentation. To the extent that such instruction is both accurate and honest, we find that it is neutral, insofar as most materials relating to drugs are inescapably fraught with controversy, and, therefore, cannot specifically deter chemical substance abuse.

We recommend repeal of these sections. We recommend that drugs and alcohol be discussed within the educational system, both with children and with their parents, as an incident of consumer education. We find that the absence of sales resistance to drugs is not categorically different from the absence of sales resistance to the promotion of consumer products and services. We do not believe that drugs should be singled out for special attention, but that all citizens should be well versed in the science of skepticism: with regard to advertising, to political theories, and to social programs. To the extent that any portion of the choice to use drugs is rational, we believe that students and their parents may need to be better logicians, but we are frankly skeptical of attempts to dissuade drug use through processes of reason alone.

4. We find that one of the few specific programs directed to prevent substance abuse which has been effective is a secondary alcohol prevention program in Dade County, Florida, known as the Driving Under the Influence of Alcohol Countermeasures Program. It is reliably reported that this program has reduced recidivism of drunk driving from twenty percent to three percent in the Miami

area. We recommend that the Commissioner of Motor Vehicles and the Commissioner of Mental Hygiene jointly establish a similar New York State Driving Under the Influence of Alcohol Countermeasures Program. Model legislation enacting this proposal is appended to this report.

Delivery of Community Health and Mental Health Services

1. We find that health and mental health services are delivered in a fragmented fashion, often inaccessible to a particular community, organized around the different medical specialties for the convenience of the medical system rather than the patient, and with no provision of follow up services.

We recommend that New York State give high priority to the development of comprehensive health and mental health services, to operate on an appointment basis, and to be situated in conveniently available sites, either in one building or in a contiguous complex, in neighborhoods of all income levels, staffed to provide immediate and careful follow-up services, including home visits; and that, where necessary, transportation or reimbursement for transportation be supplied.

2. We find that those few pilot projects where there has been a tie-in between medical and psychological services and the school system, such as that between the Learning Disorders Unit of New York University Medical School and P.S. 116, or that between Astor Home Family Counseling Service and P.S. 21, are productive, make a discernible and measurable impact to improve child and family functioning, and should be supported with public funds.

Children and Families

We find that at present social services to children and families are available only after the family is in crisis, rather than to prevent crisis, and these are usually the most expensive, most disruptive of family life, and least effective kinds of service.

We recommend that this state reorder public funding priorities in the social services to provide a sufficiency of those services which strengthen family structure, such as homemaker service, quality day care and after-school supervision and family counseling.

The Media

Alcohol

1. We find that the positive descriptions of alcohol use in the media are so frequent and so pervasive that young people, who can appreciate that alcohol is the most abused drug in the United States, have difficulty reconciling such favorable depictions with the premise that any form of chemical substance abuse, including drugs, may be harmful.

2. We find that negative representations of the effects of alcohol have no demonstrable effect on the general public. The reason for the success of the Dade County Driving Under the Influence of Alcohol Countermeasures Program is that once a drunk driver has been apprehended and convicted he, unlike the general public, can no longer

react to educational techniques with a view that the problem does not apply to him.

3. We find that the continued promotion of beer and wines on television has contributed to the upsurge in alcoholic beverages use by the young people of our state, and that such promotion, particularly of wines, is calculated to have precisely such an effect. In light of the high incidence of wine-alcoholism of France and Italy, which produces such extremely severe rates of mental illness and premature organic deterioration and death, we recommend that unless voluntary action is taken by broadcasters, the Federal Communications Commission should seriously evaluate the banning from the broadcast media of all promotional material relating to alcoholic beverages.

4. We find that the humorous presentation of alcohol abuse in television programming further contributes to a permissive climate encouraging chemical abuse by youngsters. We believe that such presentations would shock and offend all decent citizens if they were made with reference to heroin, yet there are twenty times as many alcoholics in America as there are heroin addicts. Consistent with our obligations under the First Amendment not to interfere with program content, we simply suggest that those creative people in television who originate situations making light of alcohol abuse might be better advised to address their talents to other subjects.

5. We recommend that publishers of printed media seriously reconsider their decisions not to require cautionary statements on advertisements for alcoholic beverages. We believe such statements would tend to heighten the credibility of other statements by authority figures regarding drug abuse.

6. For similar reasons, we suggest that the Surgeon General, the Secretary of the Treasury and the Federal Trade Commission evaluate the advisability of requiring cautionary notices on all packages containing alcoholic products.

Drugs

1. We find that media efforts to discourage illicit drug use have been counterproductive. Rather than frightening young people away from drugs, they have frightened potential employers away from hiring reformed addicts; and, by lowering even further the self-esteem of troubled youngsters already experimenting with drugs, they may even be contributing to the reenforcement of illicit drug use. We recommend that such campaigns as "Don't Join the Living Dead" be indefinitely sequestered.

2. We find that the promotion of over-the counter drugs on television violates the fairness doctrine of the Federal Communications Commission. Only rarely is any minor complaint ever shown on television except in the context of a drug remedy. We believe that the simple concept of fairness requires that the FCC act to make substantial time available for counter-commercials, not produced by the pharmaceutical industry, which would explain alternatives to drug use for minor discomforts, as well as preventive techniques for avoiding such discomforts.

We do not regard pharmaceutical industry efforts to caution people about medicines as sufficient. We believe such industry-produced counter-commercials simply draw attention to drugs and will not deter misuse of home remedies. We recommend counter-commercials which say nothing about medicines, but which do discuss non-chemical techniques of preventing and relieving minor illnesses, aches and pains.

Alternatives to Drug Abuse

Community Centers

We endorse the establishment of Teen Drop-In Centers, such as those in Onondaga County, which are partially funded by Narcotics Guidance Councils. Such centers may create an atmosphere which renders drug and alcohol abuse irrelevant. However, we recommend that such centers be funded because they are valid in and of themselves, and that they not be required to justify their continued financial support by attempting to prove that they are preventing drug abuse.

Conclusion

We have found that there is no direct way to prevent the abuse of chemical substances in our society, apart from treatment after the fact, regulation of the manufacture and distribution of therapeutic drugs, and vigorous law enforcement. We believe that one inescapable factor in this situation is society's acceptance of alcohol and we believe that the media has not quite caught up with the realization of this by most Americans. We believe that even more important than the acceptance of alcohol, however, as a contributing factor in the abuse of chemicals, is our unwillingness to direct our attention to the impediments to individual achievement in our society, except in terms of remedying symptoms such as drug abuse. We urge measures to strengthen family life; to help schoolchildren overcome learning difficulties, emotional and medical problems; to better living conditions in neighborhoods and communities; and to provide greater employment opportunities.

We believe that measures such as these will contribute substantially to making drug use irrelevant to any salient human need in our state, and we believe _that_ is the only valid form of drug abuse prevention.

CHAPTER I

THE DRUG SITUATION

1. Arrests for narcotics trafficking have substantially decreased over the past two years. This is largely attributable to a desire by enforcement officials to observe, rather than arrest, lower echelon dealers so that cases may be solidified against higher echelon distributors. Arrests now tend to focus upon major drug dealers, which creates an interruption in the flow of narcotics, and should promote at least a brief occasion for addicts to seek treatment.

2. However, even though the flow of heroin has been more frequently interrupted, according to the Chairman of the Drug Abuse Control Commission, quoted by The New York Times on January 11, 1974, the expected increase in enrollments in treatment programs as a result of the new law has not materialized.

3. Potentiation of the drug problem is now more evident with wider illicit distribution of cocaine, methadone, barbiturates and other medicinal compounds than ever before. Often, such transactions involve persons inexperienced in the drug traffic, who believe that because heroin creates physical addiction in 70 to 100% of the people who try it, other drugs which create only psychological dependence or less intense physical addiction are safe to sell to their peers.

4. Alcohol abuse is now seen, not only in conjunction with depressant abuse, but independently as a form of juvenile deviancy on a scale unprecedented since the 1920's. Hearings

throughout the state, and particularly on Long Island, have produced testimony to the effect that alcoholism, apart from mental illness, is now being seen in age groups 18 to 25 for the first time in decades, and children are seeking and entering treatment for problem drinking even in their pre-teen years.

5. Violent crime has increased, particularly in suburban areas. Such increase gives further credence to the view that drug abuse is but one symptom of a more generalized malaise.

Sometimes violence occurs in the drug scene. More often it occurs subsequent to the ingestion of alcohol. Increasingly, however, we find it is occurring without chemical precursor and without provocation. It is no longer rare to hear of assaults and homicides against robbery victims who do not resist and who provide substantial booty to their assailants. Without the slightest let-up on enforcement, the Commission finds that our state can no longer afford to ignore the underlying impediments to individual achievement which produce these symptoms.

ALCOHOL IS A DRUG

No discussion of drug abuse prevention would be credible, let alone complete, without an analysis of the problem of alcohol use, alcohol abuse and alcohol-related illness in New York State. The facts are simple, but they require the attention of the state's lawmakers.

Alcohol is a chemical which acts as a central nervous system depressant. Its action is not substantially different from that of other depressants. Alcohol is often used in conjunction with other drugs. When used with narcotics or antihistamines, which are also depressant substances, the effects are additive: the symptoms of the use of one are seen in tandem with the symptoms of the use of the other. When used with depressant sedatives, such as barbiturates, methaqualone, Librium and Valium, the effects are potentiative or synergistic: the symptoms of the use of one expand the symptoms of the use of the other. It is this synergism which can lead to the unintentional ingestion of a sufficient quantity of both such substances to depress the respiratory process drastically and thereby cause death. There is full agreement among all authorities that this process actually occurs, and there have been frequent reports to this Commission that street abuse of depressants almost invariably is accompanied by the ingestion of alcohol or potentiated by the abuse of alcohol.

Unemployed users of methadone frequently turn to alcohol, and heroin users also have been known to drink heavily for the added effect of the alcohol. According to former New York City Police Commissioner Donald F. Cawley, the first six months of 1973 saw 377 homicides reported. The Medical Examiner found both narcotics and alcohol in 131 of the corpses, or 36.8%.

Then Secretary of Health, Education and Welfare, Elliott Richardson, issued a report to Congress entitled, Alcohol and Health in December of 1971. That report cited studies which showed that between 50 and 55% of those offenders who had committed homicides had been drinking. Chronic excessive alcohol use is associated with one-third of all reported suicides. 56% of injuries in fights were sustained by people who had been drinking. 57% of fatal non-automobile accidents involved persons who had been drinking. Of those accidents which were non-fatal, alcohol was implicated in 22% of the accidents in the home and in 30% of the non-driving transportation accidents.

Nationally, one half of all automobile accident fatalities involve individuals whose autopsies reveal alcohol in their bloodstreams. One of the reasons for this is that a pharmacological effect of alcohol is that it causes an underestimation of speed. Among drivers between the ages of eighteen and twenty-five, the proportion of drinking fatalities is raised from 50% to 60%.

According to the New York State Department of Motor Vehicles, some 3,238 persons were killed in automobile related accidents in 1972. Another 338,557 persons were injured. The New York State Mental Hygiene Department estimates that at least half of each of these figures involved alcohol. Under New York State laws, driving while intoxicated requires a finding of .10 percent alcohol in the blood. Extrapolated statistical breakdowns from the New York State Police indicate that about 48% of the drinking victims who died showed blood alcohol levels below .06 percent. 52% showed even higher blood alcohol levels. However, approximately 19% showed blood alcohol levels of between .06%

and .11%. There may be good reason, then, for New York State, following the model of Great Britain and of several other states of the Union to lower the blood alcohol level to .05% to determine culpable unsafe driving due to alcohol intoxication.

Accidents are not the only concern of policymakers. With an estimated one million alcoholics and problem drinkers in New York State, public health concerns are greatly complicated and increased by alcohol use. The New York City Department of Mental Health and Mental Retardation Services informed the Commission that studies conducted at Bellevue and Harlem hospitals in 1969 indicated that 58% of the men who were in-patients and 37% of the women who were in-patients were alcoholics. That is a total alcoholic census of 47%. Deaths related to alcohol use in New York City number approximately 6,000 each year. Alcoholism ranks fifth as a cause of death in New York City, and in some ghetto areas it ranks as high as third. Although poor people, nationally, have the highest percentage of abstainers, they also have the highest ratio of those who cannot drink without developing serious drinking problems and alcoholism.

The Commission has found that alcohol use and particularly alcohol use among children, is increasing at an alarming rate. In New York State, young people between the ages of 15 and 20 drink regularly (57% of boys and 43% of girls). Alcoholism, usually seen in older people, is now becoming common in the age group of 18 to 25. And recently, treatment programs such as Phoenix House, have begun to see children barely in their teens who have already felt the need to seek help for their drinking.

Alcohol use results in conditions which are seen as cumulative of a process of organic deterioration. Some of these conditions are reversible, with treatment and the cessation of alcohol use, and some are not reversible. It is well known and has been thoroughly documented that heavy social drinking can lead to alcoholism in from 3 to 20 years. Over an extended period of time, the liver and the central nervous system experience the greatest damage. Although alcohol may be recommended by physicians in small quantities for medicinal use, prolonged self-administration inevitably leads to psychosis, cirrhosis, or heart disease and, resultantly, premature death. While it was briefly held, at one time, that nutritional deficiencies were more significant in the deterioration of drinkers than the intake of alcohol, itself, this modish fantasy has been extinguished by medical research.

This Commission believes that there are other significant myths about alcohol which ought to be dispelled. One such myth is that the public is not aware of the accident and health dangers of problem drinking. Approximately 70% of the American people are drinkers. 75% of the general public thinks drinking "does more harm than good". The same 75% believe that drinking is a serious public health problem. And about one-tenth of the drinkers who responded to a national questionnaire were worried about their own drinking.

An Oregon advertising agency was asked to conduct an opinion survey in that state by the Oregon Liquor Control Commission, in July of 1973. The alcohol consumption in Oregon is about at the national average and considerably lower than that of New York State (2.54 gallons of absolute alcohol per drinking age person per year as opposed to 3.09 gallons for drinking age New Yorkers). Many of the responses of the interviewees were compelling. For example, when asked about the cause of alcoholism or problem drinking, 52.5% answered: "personal problems with which the individual cannot cope". Only 13.5% believed that excessive intake of alcohol was the cause, and only 19.4% believed in the theory of addiction-prone personalities. Other responses were either blank or registered as unsure. While 51.1% agreed that most people who drink do not develop serious drinking problems, 60.3% disagreed with the notion that alcohol should not be considered a dangerous drug. Given a fact situation in which a person who had been drinking "too much" felt that he had to drive home, 77.6% said such a person should be arrested for drunk driving and 83.6% said driving while intoxicated is not all right simply because the individual is not caught. 81.1% further disagreed with the idea that traffic accidents are caused by problem drinkers rather than social drinkers. 58.7% also disagreed with the proposition that drunk driving should be excused on the basis of a good driving record, but 71.9% did not feel that the person who serves alcohol to someone who is later arrested for drunk driving should be penalized.

It has often been said that alcohol use is so much a part of our way of life, that attempts to regulate personal conduct subsequent to alcohol use might not be easily received by the public. Consider, then, some of these answers by Oregonians. Although 84.5% agree that drinking is a normal part of American life, the majority call the following uses of alcohol unacceptable: 73.5%, drinking to loosen up before an important meeting; 82.9% with regard to drinking to gain relief from personal problems; 53.2% are against drinking as a "social lubricant" to accelerate interaction at a party; and 69.6% oppose drinking to reduce the tensions of daily living. On the subject of relaxing after work, the responses were about evenly divided, with a slight, but not a majority edge, opposed (41.6% to 47.9%). 71% said that a proprietor should refuse to sell alcohol to a known problem drinker and 68.5% said the same about a person giving the appearance of having been drinking.

The results of national polls and the Oregon sample indicate a public awareness of alcohol-related problems and a readiness to accept wider support for the treatment and prevention of such problems.

Another myth relating to alcohol which is frequently put forward by militant drinkers, the Licensed Beverage Industry, and by advocates of the legalization of marihuana and other drugs is that Prohibition did not diminish alcohol use. The Richardson Report refutes that myth by pointing out that alcohol use, per drinking age person, has declined substantially only once in our history, and that was during Prohibition. Ever since 1934, when per capita intake was 0.97 gallons per year and the Prohibition amendment to the Constitution had just been repealed, alcohol intake has increased fairly steadily to a national average in 1970 of 2.61 gallons per drinking age person per year. During Prohibition, a determined minority, perhaps even a determined majority, flouted the law. The argument that the law was not effective in reducing alcohol intake, however, is simply not true.

A final myth requires attention. It has been alleged by some that drinking style has some bearing upon the subject of whether or not the use of alcohol may turn into problem drinking or alcoholism. It is said that if low-alcohol content beverages, such as wines, are ingested slowly and with food, in the Continental manner, problems are less likely to arise. Those who argue this position may not be entirely familiar with the fact that the highest rates of alcoholism in the world are to be found in France and in Italy. The Italian Istituto di Cultura in New York City has officially reported to the Commission that the Italian Government regards alcoholism as the most serious public health problem in Italy today. While only 21% of the driving accidents in Italy appear to be alcohol related, enforcement laxity may account for some underreporting. However, assuming that such violence as may exist is less related to alcohol use in Italy than in the United States, the prospect of seeing even larger numbers of people ending their lives in psychiatric institutions as a result of alcohol use in the Continental fashion should give us pause. Violence is only one of the social disutilities of extensive drinking. The health, welfare and emotional stability of a population must also be weighed carefully.

Awareness of the possible consequences of alcohol use, a lack of ambivalence about alcohol use, and disapproval of inappropriate alcohol use are not effective deterrents to alcohol abuse. It has been said that the way to prevent alcohol abuse is to help people develop better values relating to alcohol, itself. This Commission believes that there is nothing wrong with the values of people as they relate to alcohol use. The problem, we believe, is a twofold one of reenforcing values which already exist and dealing with the personal and societal problems which undercut such values. When ten percent of the people who drink are, themselves, worried that they are drinking too much, and when about the same percentage of drinkers are, in fact, problem drinkers, we cannot see that the values of drinkers which relate to alcohol are the primary source of difficulty or confusion.

The question of reenforcing appropriate values which relate to alcohol and drugs will be dealt with more fully in the chapters of this report devoted to Education and to the Media. It is significant to note, however, that although drinking occurs most often among "friends", people who drink are more likely to drink among co-workers than they are to drink among "close" friends. In other words, the use of alcohol is less frequent, perhaps less necessary, in a supportive non-stressful situation than in a situation which may evoke feelings of rivalry. It may be useful to consider the possibility that although some drinkers do not wish to drink, they do so because their other values -- such as competing for success -- require them to drink, either because they are competitive, or because they believe that they cannot otherwise see their way through artificial social situations which make demands on them to be everything but themselves. In either case, alcohol use and abuse may be the price we simply do not know how to avoid while pursuing our personal goals and our goals as a society. It is in this context that we shall discuss reenforcement of preexisting values regarding alcohol.

This Commission finds that the personal and societal problems which invite alcohol abuse are in no way different from the problems which invite drug abuse.

THE ETIOLOGY OF DRUG AND ALCOHOL ABUSE

In 1972, a Commission Task Force had occasion to visit several other countries to study how people overseas deal with drugs (Commission Report, Legislative Document No. 11, 1973). The Task Force, led by our former Chairman, Chester R. Hardt, visited the famed Jellinek Klinik in Amsterdam. The Jellinek Klinik began as a treatment center for alcoholics; then, in later years, was expanded to accept narcotics addicts. Answering a direct question from one of the Commission staff members, E.M. Jellinek, founder and Director of the Klinik, stated that he could perceive no differences between the etiology of narcotic addiction and that of alcoholism.

To prevent drug or alcohol abuse, a proper assessment must be made of the causes of these problems. The Commission has now studied the causes of drug and alcohol abuse for three years. Testimony has been adduced throughout the state in public hearings and private conferences. Learned papers and articles have been received by the Commission and researched by the staff. Treatment programs and prisons have been visited both here and abroad. Top authorities in the fields of drug treatment, alcoholism rehabilitation, child care, adolescent medicine, crime prevention and control, psychiatry, education, nursing, family medicine and counselling have been consulted. The Commission believes that the time has now arrived to make definitive findings regarding the causes of drug and alcohol abuse, and which causes appear to be suitable for further preventive efforts by government.

First and foremost, the cause of drug and alcohol abuse is not a paucity of information. People who know they are likely to contract heart disease, lung cancer and other pulmonary illnesses continue to smoke or take up the habit. People who know they are likely to be killed if they are involved in an automobile accident after ingesting an amount of alcohol which leaves a concentration of more than .10 percent in their blood, continue to drink before driving. And people who have seen their own friends and even older brothers and sisters die or become severely dissipated by drug addiction take drugs.

The changing nature of society, however, may bear, at least indirectly, on the causes of drug and alcohol abuse. Many of the policies and programs of the past thirty years have only partially succeeded in relieving the state's social problems. Although this might have been expected, what has compounded the difficulty in dealing with remaining aspects of these problems has been the rapid change in social conditions which has come to be popularly known as "future shock". It is not the individual, alone, who experiences a sudden sense of disorientation because of stunningly rapid changes in values, culture and technology. Events and circumstances are so quickly altered that even the most conscientious government agencies can sometimes become bewildered by the combination of unfinished known tasks, such as the accessibility of good health care, and the evolution of new problems. As the New York State Regents reported in 1970;*

> We have labored under the misconception that as we become more technologically advanced, we will necessarily overcome our health problems. The opposite is happening. The very technology that makes life comfortable and solves some of our old health problems also produces new and more sophisticated health concerns.

In the 1950's drugs were still primarily a Black problem. As late as 1969, the federal government estimated that nearly 50 percent of the heroin addicts were Black, despite their 12 percent overall representation in the general population. Clearly, however, the heroin problem had begun to spread. Lower-middle-class whites began to show up in hospitals with addiction-related problems; then middle class people began to seek help for drug-related problems; and, finally, a cross-section representation of all levels of society was seen, eked out by wholesale youth experimentation with a variety of other mood-altering substances, some lawful and others not. Absolute alcohol consumption which had increased over one-half gallon per drinking age person in the United States during World War II, continued to increase another three-tenths of a gallon by 1970, making the United States seventh among drinking nations of the world, ahead of the Scandinavian countries, Britain and Ireland. Again, as with drugs, the lowest income people were the likeliest to develop problems with drinking.

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*State Education Department Position Paper No. 9.

As the problem of drug abuse began to cut across economic lines, and as the use of alcohol to excess began to emerge as a symptom of the malaise of affluent youth, many responsible people, confused by changing events, decided that remaining poor social conditions could not be a continuing cause of substance abuse, and, therefore, society had to look elsewhere for solutions to the drug problem. We believe that in the pursuit of drug abuse prevention the known tasks of helping those people whose concrete problems still leave them demoralized and hopeless, such as unemployment, poor health care, inadequate mental health services and substandard housing, need not be and should not be discontinued.

The Commission is encouraged by Governor Wilson's commitment to improving the conditions which exacerbate social problems in this state. We also endorse the Governor's commitment to improve programs relating to "young people in need of supervision, neglected, abused and dependent youth, and children with handicapping conditions."

The fact that abstract problems among people who have less concern about meeting their concrete needs may also create a climate hospitable to substance abuse must also be considered. The immediate cause of substance abuse, this Commission has concluded, cuts across socio-economic class lines and may be stated as the inability of individuals to find, or function well in, activities which give them a sense of self-esteem. A spokesman for The New York City Special Services for Children, which services 28,000 children in foster care and 12,000 children in alternative programs, said in a letter to the Commission: "I believe that drugs are used to compensate for feelings of ineffectiveness. Thus, inability to achieve in the school, at the job, or in our success oriented society generally would seem to be the strongest contributing factor to the use of drugs."

Similarly, a spokesman for the Child and Family Services of Buffalo said:

"It would appear that an extremely high correlation exists between drug use, excessive alcohol use and delinquency on the one hand, and previously undetected and untreated organic, nutritional, perceptual and emotional disabilities, on the other. The significance of this correlation seems to be in the fact that oftentimes these individuals find themselves confused, frustrated and unable to find answers for the differences they find between themselves and others. As a consequence, the facade of solace which drug use often carries becomes attractive to the individual possessing negative perceptions of himself."

Every letter, written statement and oral presentation at our public hearings which dealt with the personal attitude of the substance abuser (but not the recreational experimenter), commented that poor self-esteem was the invariable common denominator of substance abuse. Moreover, one of the most frequent statements made by treatment programs, both for alcoholism as well as drug abuse, was that raising the self-esteem of the individual is an absolute prerequisite to successful rehabilitation. Drug abuse prevention is, then, a realistic method of helping people develop true self-esteem, so that they may bypass substance abuse altogether.

Because poor self-esteem is not an unusual phenomenon, and because most young people who experiment with drugs or who drink alcohol do not become destructive to themselves or others, the Commission sought and isolated two particular factors which we find to be highly significant in the causal chain between a poor subjective perception of oneself and substance abuse. One deals with inadequacies in family life, the other with inadequacies in the schools.

At our hearings throughout the state, we asked a variety of experts in the fields of drug treatment, drug abuse prevention and child care about the parents of substance abusers.

Surprisingly, we heard that between 50% and 90% of all serious substance abusers have at least one parent who is a serious substance abuser. Children are aware of the correlation, themselves. On May 13, 1970 a Port Washington, N.Y. high school released the results of a student survey which purported to show that twice as many students with one parent (the mother) who had been seen drunk used marihuana. More compellingly, Smart and Fejer of the Addiction Research Foundation, Toronto, Canada, reported on the correlation between parental drug use and drug abuse among children in the Journal of Abnormal Psychology.* A scientifically verified and widely accepted study of students at a high school in Toronto, grades 6 through 13, revealed the following:

1. Mothers' use of alcohol and/or tobacco as reported by students was more closely related to student use than was fathers' use. In general, the percentage of students reporting using tobacco, marijuana, barbiturates, opiates, speed, stimulants, tranquilizers, LSD, and other hallucinogens was lowest if the mothers used neither tobacco or alcohol and highest if she used both. Mothers who used only alcohol tended to have students who were users of alcohol more often than when mothers only used tobacco or both alcohol and tobacco. Student use of glue was most frequent when the mother was reported to use only tobacco. Parental use of alcohol appeared to be underreported by the students.

2. The extent of drug use among children of mothers who were reported as daily tranquilizer users was perhaps most striking. About 28.8% of their children used marijuana, 11.0% used opiates, 9.5% speed, 15.5% other stimulants, 31.1% tranquilizers, 14.8% LSD, 15.9% other hallucinogens, 9.8% glue, and 13.3% barbiturates. With regard to use of tranquilizers by fathers, 36.3% of those who reported daily use of tranquilizers by their fathers also used tranquilizers.

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*"Drug Use Among Adolescents and Their Parents: Closing the Generation Gap in Mood-Modification," Vol. 79, No. 2 (1972).

3. These relationships were also found for parents who used stimulants.

While Fejer and Smart do not see their studies as establishing a causal link between alcohol and drug use among parents and resultant alcohol and drug use among children,* they do infer that parents may transmit to their children, howevery unwittingly, an acceptance of mood-alteration by substances as a method of solving problems.

Based upon the frequent responses of drug abuse prevention workers and child-care experts, the Commission draws a slightly different inference. Substance abuse in youngsters can occur in families where parents do not abuse substances. And abstinence among offspring is surely not unknown in families in which parental substance abuse occurs. The common factor is not parental substance abuse, per se, we believe, but an inadequacy in transmitting valid techniques for solving family and personal problems without recourse to alcohol and drugs. It is this inadquacy which contributes to a lowering of self-esteem among family members and a diminution of mutual respect between parents and children.

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*Compare, for example, "Alcohol Problems in Adoptees Raised Apart from Alcoholic Biological Parents," which offers the hypothesis that exposure to an alcoholic parent for even a few months at the beginning of life may lead to alcoholism of the offspring in later life.(Arch. Gen. Psychiatry, Vol.28, Feb. 1973).

Fejer and Smart, along with many other experts, advise adult education for such parents. The Commission supports this recommendation which will be integrated in the chapter of this report entitled "Education: Scaling the Problem Down to Size."

The second factor of great significance, we believe, in the causal chain between poor subjective perception of oneself and substance abuse is the inadequate detection and remedy of learning problems among children, when such problems fall short of constituting gross physical or emotional handicaps. The links in the causal chain have been established beyond question. As along ago as 1967, the New York Regional Director of the Bureau of Labor Statistics ranked lack of education, interrupted education and educational failure as the most important causative factor in unemployment.*

At any point on the continuum to failure, the Commission finds that individuals are most susceptible to substance abuse. For example, if self-esteem is critical to abstinence, the Fleischmann Commission Report (1972) spoke of reading competence as the key to self-esteem:

> No element of formal schooling is more essential than learning to read. Functional literacy is not only a prerequisite to meeting daily requirements, it also helps determine an

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*DISADVANTAGED CHILDREN, Health, Nutrition and School Failure, Birch and Gussow, Harcourt, Brace and World, Inc., New York, 1970.

individual's economic and social status and his estimation of his own worth. (Emphasis added.)

We plan to discuss in greater detail in our chapter on education the concept that reading is not only important as a tool to be used to achieve scholastic success and higher earnings, but that reading is the key to abstract thinking and the ability to relate dissimilar trends and observations for the purpose of resolving personal as well as social problems. Producing children who can read (and can understand mathematics) is only the preliminary objective of an educational system. Producing children who can think clearly is the desired ultimate goal with regard to both education and drug abuse prevention.

Impediments abound, however, even with regard to the preliminary objectives of teaching children literature and mathematics. This report will not deal with major handicaps, such as muscular dystrophy, not because such handicaps do not warrant attention, but because our mandate extends only to conditions which may form an etiological link in the causal chain leading to deviant behavior and substance abuse. Learning impediments which form such a link may be seen as three aspects of neglect of the young. These include failure to detect or treat perceptual and physical disorders, failure to detect or treat emotional and family problems, and failure to compensate for learning problems associated with cultural deprivation.

The Commission has found that these three aspects of indifference to the well-being of children in our state directly contribute to substance abuse. We have made this finding based upon repeated testimony and replies to questionnaires which indicate that substance abuse is more likely to occur among school failures and unemployables than among others and that treatment programs rarely encounter substance abusers* who do not exhibit previously undetected or untreated remediable learning impediments.

Although the Drug Abuse Control Commission has not been able to provide overall statistics, individual drug prevention and treatment programs have reported a sufficient incidence of such learning impediments to demonstrate this thesis. Young people who are abusing drugs and alcohol and not otherwise functioning well in school invariably exhibit signs of the three aspects of neglect previously discussed. Uncorrected vision and hearing deficits are most common. Indeed, top officials of the State Education Department report that large areas of inner-cities have been without eye-chart vision tests for some time. As if this were not enough, more subtle learning problems have eluded teachers with tragic results. A sixteen-year-old drug user in a residential facility suffers from a lack of optic coordination which is remediable with exercises. His condition was never detected, in nine grades of school. Now he not only cannot read, but he believes that he is severely mentally retarded. A thirteen-year-old drug user was cuffed on the ear as a small child by an alcoholic father. Resultant hearing loss was never detected. Adolescents referred for treatment and rehabilitation are unable to perform the simplest of learning tasks, because such inability was never assisted on an individual basis.

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*among those who are not functioning well as workers, students or homemakers

The basic causal connection between learning impediments and substance abuse has been inferred by our Commission as the logical result of such problems. We base our conclusion upon reports from various treatment programs, books, papers and studies which connect school failure with biological problems and which connect deviancy with school failure. While we cannot prove that remedying such problems will invariably promote abstinence, we shall prove that such a course is right for its own sake and that it has a greater potential for preventing substance abuse than other concepts of prevention which are currently being implemented.

Note: Because the Commission has not fully researched the question of tobacco abuse as a form of substance abuse, we are appending to this chapter the most incisive analysis we have seen on the 10-year effects of the Surgeon General's Report on cigarette smoking. It is a New York Times article by Jane Brody, which appeared on January 11, 1974.

THE NEW YORK TIMES JAN.11, 1974

Decade's Warnings Fail to Cut Smoking

By Jane E. Brody

Ten years ago today, the Surgeon General of the Public Health Service issued a momentous report citing cigarette smoking as a major hazard to life and health. Yet, on the anniversary of that historic, 387-page document, cigarette sales are at a record, per capita consumption is increasing and 3,000 teenagers are becoming new smokers each day.

Despite repeated scientific confirmation of the Surgeon General's warnings, an ever-expanding list of smoking-related risks, an intense educational effort, restrictions on cigarette advertising and a growing force of nonsmokers seeking to limit smoking in public places, about 40 per cent of men and 30 per cent of women are current cigarette smokers.

An estimated 10 million Americans, mostly men, have quit cigarettes since the report was issued, but the population growth and a steady influx of new smokers have increased the ranks of current smokers from 50 million in 1964 to 52 million today.

However, public health officials estimate that the report and the studies, warnings and educational efforts it generated helped to reverse a trend that otherwise would have meant 75 million smokers today.

At the same time, concern over health has led to an increasing use of cigarette filters and tobacco substitutes that, in turn, has resulted in an 18 per cent drop in per capita consumption of cigarette tobacco and a 32 per cent decline in tar and nicotine content.

Thus, smokers of today are puffing on less potent and, presumably, somewhat less harmful cigarettes than a decade ago, although there is not yet proof that their risk is reduced.

The tobacco industry, while continuing to maintain that cigarettes are not the health hazard they are made out to be, has nonetheless catered to the public demand for less tar and nicotine.

Dr. Luther L. Terry, the former Surgeon General, who issued the 1964 report, said, "In general, I'm encouraged by the progress of the last decade and optimistic about the future. But I also have some important reservations."

"I'm most discouraged by our lack of success with youth," he explained. "There hasn't been a significant drop in smoking among young people. In fact, they're starting at earlier ages and there's been a dramatic increase in the percentage of girls who smoke."

New 'Bill of Rights'

As a consultant on tobacco and health for the American Cancer Society and a member-at-large of the National Interagency Council on Smoking and Health, Dr. Terry has dedicated much of the last decade to combating smoking and supporting nonsmokers in their efforts to breathe air free of tobacco smoke.

Today, in Philadelphia's Congress Hall, the former Surgeon General is participating in the adoption of the "Nonsmoker's Bill of Rights," sponsored by the interagency council. The bill proclaims the right of nonsmokers to breathe clean air (which "supersedes the right to smoke when the two conflict"), the right to speak out about their discomfort in the presence of tobacco smoke, and the right to act in legitimate ways to restrict smoking in public places.

"The nonsmoking movement has just begun to show itself and already it has made substantial gains," Dr. Terry remarked.

Increased Awareness

Airlines are now subject to $1,000 fines for failing to provide a smoke-free seat for any passenger who wants one; the Interstate Commerce Commission has just made "no smoking" the rule, rather than the exception, on all passenger trains; the military has begun to segregate smokers and has stopped distributing cigarettes in C-rations; a growing number of restaurants now offer segregated areas for nonsmokers; Arizona has banned smoking in a wide variety of public places, and similar legislation has been passed or is being considered in many cities and states as well as in Congress.

All these efforts have enhanced public awareness of cigarettes and made the smoker increasingly self-conscious and, at times, uncomfortable about his habit. Indeed, some experts believe that in the future a decline in the social acceptability of smoking will do more to swell the ranks of former smokers and nonsmokers than the continuing barrage of ever sterner health warnings.

Few doubt, however, that health risks have been the primary motivation for most of the 29 million Americans who have already become former smokers.

The 1964 report cited cigarette smoking as the major cause of lung cancer and chronic bronchitis, as an important cause of cancer of the larynx and as associated with an increased risk of cancer of the bladder and esophagus, heart disease, peptic ulcer, cirrhosis of the liver and the smallness of babies at birth.

In the decade since, these risks have been repeatedly demonstrated--in studies in Japan and Great Britain as well as in the United States. And the list of smoking-associated hazards has grown to include cancer of the mouth, pharynx, pancreas and kidney; atherosclerosis and several vascular diseases, and periodontal (gum) disease. Cigarettes are now established as a major cause of emphysema and as an important contributing cause of death from heart disease.

In Britain, as in the United States, cigarette smoking is now the largest single avoidable cause of death and disability. Sir George Godber, Britain's chief medical officer, has reported that cigarettes are responsible for nine in 10 lung cancer deaths, three in four chronic bronchitis deaths and one in four deaths from heart disease.

The data available in 1964 were based on studies of men, with only a suggestion that women might face similar risks. In the intervening years, it has been shown that women smokers also face a greatly increased risk of lung cancer, heart disease, cirrhosis of the liver, emphysema and cancer of the mouth, pharynx, esophagus, pancreas and bladder.

Effects Upon Mothers

And mothers who smoke during pregnancy have been shown to be more likely to experience miscarriage, stillbirth and death of the newborn child. Smokers' babies tend to weigh less at birth and, according to British findings, tend to perform less well academically and socially at the age of 7 years.

All told, the Public Health Service conservatively estimates that 300,000 Americans die prematurely each year because they smoked cigarettes. In addition, a National Health Survey found that there were 12 million more chronic illnesses among adult Americans than there would be if everyone had the illness rate of nonsmokers.

Accordingly, smokers miss 40 per cent more days of work (a total of more than 77 million working days), make more visits to the doctor, spend more days in the hospital and undergo more surgery than do nonsmokers.

In addition, the children of smoking parents have twice the incidence of respiratory illness found in nonsmoking families.

Role of Carbon Monoxide

Scientists have also begun to delineate the specific effects of tobacco smoke and to identify the factors that may cause harm. Among other things, tobacco smoke has been found to interfere with the natural cleansing mechanisms of the respiratory tract.

A number of cancer-causing components of cigarette "tar" have been isolated. Nicotine, in addition to stimulating the heart rate and raising blood pressure, has been shown to affect the cells involved in blood clotting and to interfere with immunity mechanisms that help prevent infection.

Recently, carbon monoxide, a combustion product in cigarette smoke, has been singled out as a previously unappreciated cause of damage, particularly to the heart and blood vessels. Carbon monoxide combines with the blood's oxygen-carrying pigment, hemoglobin, and reduces the amount of oxygen available to the heart and other body tissues. It has also been shown to increase the rate of artery-clogging atherosclerosis and cause swelling and degeneration of certain heart tissues.

A pack-a-day smoker has two to three times the level of carbon monoxide in his blood as the nonsmoker, and a recent nationwide study found that smoking was a far more important source of carbon monoxide in the blood than was air pollution.

The Industry Viewpoint

While most of the scientific and medical community believes, on the basis of current evidence, that cigarettes are an important cause of death and disability, some scientists and the tobacco industry, which has spent more than $30-million on smoking and health research in the last decade, maintain otherwise.

Horace R. Kornegay, president of the Tobacco Institute, the industry's trade association, said in a statement yesterday that the Surgeon General's report raised more questions than it asswered and that final answers were still not in.

He said that future research into such influences on health as "environment and pollution, sex and race differences, geography and genetics will be much more significant than what has already been done."

But while the industry keeps the smoking-health controversy smoldering, 75 per cent of current smokers acknowledge and accept the health risks of cigarettes. And more than half the current smokers have attempted to quit.

It appears, however, that most of the smokers who would find it relatively easy to quit have already done so. The ranks of former smokers consist largely of those who were light smokers to begin with or who had already developed a smoking-related illness that forced their hand.

For many, cigarette smoking is a deeply ingrained habit that is extremely difficult to break; for others, it is a source of pleasure they are reluctant to give up.

"In spite of everything -- the Surgeon General's report, the educational programs of the National Clearinghouse on Smoking and Health and other health organizations--we still have more than 50 million smokers," said Dr. Gio B. Gori, who heads the Tobacco Working Group of the National Cancer Institute. "And it is likely that this habit will continue for the next few decades, at least."

Less-Hazardous Cigarette

Therefore, the institute, in addition to supporting anti-smoking educational efforts, has decided to focus its research attention on ways of reducing the risk to those who continue to smoke.

As Dr. Gori outlined them, the institute's main lines of research include trying to identify those individuals who are at high risk of developing smoking related illnesses and finding ways to help them give up cigarettes; developing drugs that will counteract the unwanted effects of substances in tobacco smoke or mimic their pleasure-giving properties without doing damage, and trying to reduce the risk of smoking by making a less hazardous cigarette.

"This last one is the approach we think will be most successful in the long run," Dr. Gori said. "The trick is to remove the harmful substances and leave in those that give the smoker pleasure."

In one experiment, Agriculture Department scientists are trying to identify the precursors of harmful tar substances in the tobacco plant and breed them out.

Other scientists are studying new ways of curing tobacco and improving the combustion of cigarettes to reduce the amount of cancer-inducing hydrocarbons and carbon monoxide in the smoke. Filters that can selectively remove harmful substances, yet leave in pleasure-giving ones, are also under investigation.

All these studies, however, are difficult and time-consuming. Whatever the scientists come up with must be tested in laboratory animals for a minimum of two years. Some animal studies are already under way, but it will be some time before the results reach the consumer.

And some scientists oppose this whole approach, saying that cigarettes can never be made harmless and that this effort will ultimately put government health officials in the position of advocating a harmful, although somewhat less harmful, product.

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DRUG INFORMATION TEST

(taken from Jeffrey Schrank, *Teaching Human Beings: 101 Subversive Activities for the Classroom*)

Identify the Following Drugs:

1. Ordinary form: liquid. Medical use: mild stimulant, treatment of some forms of coma. Potential for psychological dependence: high. Long term effects: insomnia, restlessness. Fatal dosage: 10 grams. ____________

2. Ordinary form: pills. Effect on brain and other body organs: unknown. Danger: accounts for hundreds of deaths and thousands of illnesses each year. Has produced chromosome break-down and birth defects in lower animals.

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3. Effect: stimulates the central nervous system, inhibits formation of urine, increases adrenal activity, accelerates heart rate and raises blood pressure. Danger: one of the most toxic drugs known. Use: insect sprays (no other medical use). Average dosage: 20-30 milligrams. Fatal dosage: 60 milligrams. Potential for psychological dependence: high.

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4. Ordinary form: liquid. Duration of effect: 2-4 hours. Medical use: rare, sometimes used as a sedative for tension. Potential for addiction (physical dependence): high. Overall potential for abuse: very high. Effect: produces euphoria, impairs judgment and motor control. Legal penalties: light.

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1. Caffeine
2. Aspirin
3. Nicotine
4. Alcohol

CHAPTER II

CONCEPTS OF DRUG ABUSE PREVENTION

> *"The most appropriate response of concerned individuals toward the information that a youngster is using drugs would be an effort to understand what the use of the drugs means to the child and dealing with the child at the level of those needs rather than at the level of drug abuse."*
>
> *Mrs. Linda Schmidt*
> *Chenango County Mental Health Clinic*

Drug abuse prevention concepts may be viewed on three levels. Primary prevention denotes activities which aim at deterring drug abuse, by identifying and correcting the causative factors before a problem arises. Secondary prevention emphasizes the early identification of an individual who may be experimenting or on the brink of experimenting with drugs, and prompt intervention before the problem becomes disabling. Tertiary prevention denotes those activities designed to treat and, if necessary, rehabilitate the individual who already has a drug problem. In the past, professionals concerned with drug abuse have devoted a substantial portion of their efforts to the development and implementation of tertiary prevention activities.

TERTIARY PREVENTION

Tertiary prevention is composed of two related concepts - treatment and rehabilitation. Treatment encompasses those activities designed to assist the individual to terminate unlawful drug use.

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One major treatment modality encourages total abstinence from drug use by providing the supportive services, on an ambulatory or residential basis, necessary to wean the individual away from his dependence on drugs.

A second modality involves the administration of maintenance doses of methadone. Methadone is a heroin-substitute which blocks the euphoric effect of heroin, relieves the addict of the psychological and physiological compulsions involved in using heroin and renders him susceptible to rehabilitation.

The British system of heroin maintenance is a third treatment modality which has received considerable attention. Underlying this system is the belief that a heroin user, who is willing to forego prolonged euphoria, can become stabilized on a certain dosage of heroin which will prevent withdrawal. Numerous experts, however, disagree with this theory. They claim that stabilization on heroin is impossible because the dosage required to prevent withdrawal increases throughout treatment, because the short-term effects of the drug necessitate frequent administrations and because the individual maintained on heroin will find it difficult, if not impossible, to overcome his desire for constant euphoria, as long as the heroin is administered.

After careful investigation of the British system of heroin maintenance,* the Commission opposed the establishment of this treatment modality in New York State. The Commission found that one of the key factors contributing to England's success with this method of treatment was the existence of a National Health System which was available to provide the medical, psychological and counseling services necessary. In contrast to the single oral dose which is required to stabilize an individual on methadone for one day, maintenance doses of heroin must be administered at least four times a day by means of injection. Extensive health resources must be available to provide these frequent injections and to deal with the medical problems, such as collapsed veins and illnesses due to careless handling of needles, which may arise during the course of treatment.

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*See: How People Overseas Deal with Drugs, Commission Report, Legislative Document No. 11 (1973).

The Commission also found that the prospect of heroin maintenance undermines the attractiveness of other forms of treatment, and permits the individual to bide his time and continue his habit, even when heroin is in short supply, by using other drugs, including alcohol, cocaine, short-acting barbiturates, and, now, chlordiazepoxide and diazepam.

Rehabilitation is the second concept of tertiary prevention. It encompasses the educational, vocational, medical, psychological, employment and counseling services necessary to reintegrate the reformed addict into society.

Inherent in this concept is the belief that, by providing the individual with the opportunity to resume a productive role in society, rehabilitation will encourage drug-dependent persons to seek treatment and to abstain from unlawful drug use. Emphasis upon rehabilitation also reflects society's reluctance to support a non-productive population of drug-dependent individuals.

Treatment and rehabilitation may be considered drug abuse prevention activities insofar as they provide an impetus for the individual to discontinue drug use. With this in mind, the Commission, in 1972, recommended the expansion of opportunities for treatment* and, in 1973, introduced legislation which would prohibit discrimination in the employment of rehabilitated addicts.**

The State has expended substantial investments of time, energy and resources for treatment and rehabilitation. For 1973-74, the Legislature has appropriated to the Drug Abuse Control Commission more than $50 million for treatment and rehabilitation programs, over $56 million for Youthful Drug Abuse Programs (one component of which provides treatment and rehabilitation), almost $16 million for local methadone treatment programs and over $33 million for capital construction projects.***

From the standpoint of the individual user, these expenditures may be viewed as investments in drug abuse prevention. However, from the standpoint of the non-drug taking population, these measures are not designed to prevent substance abuse. In other words, the large amounts of support given to treatment and rehabilitation have only a post factum preventive effect.

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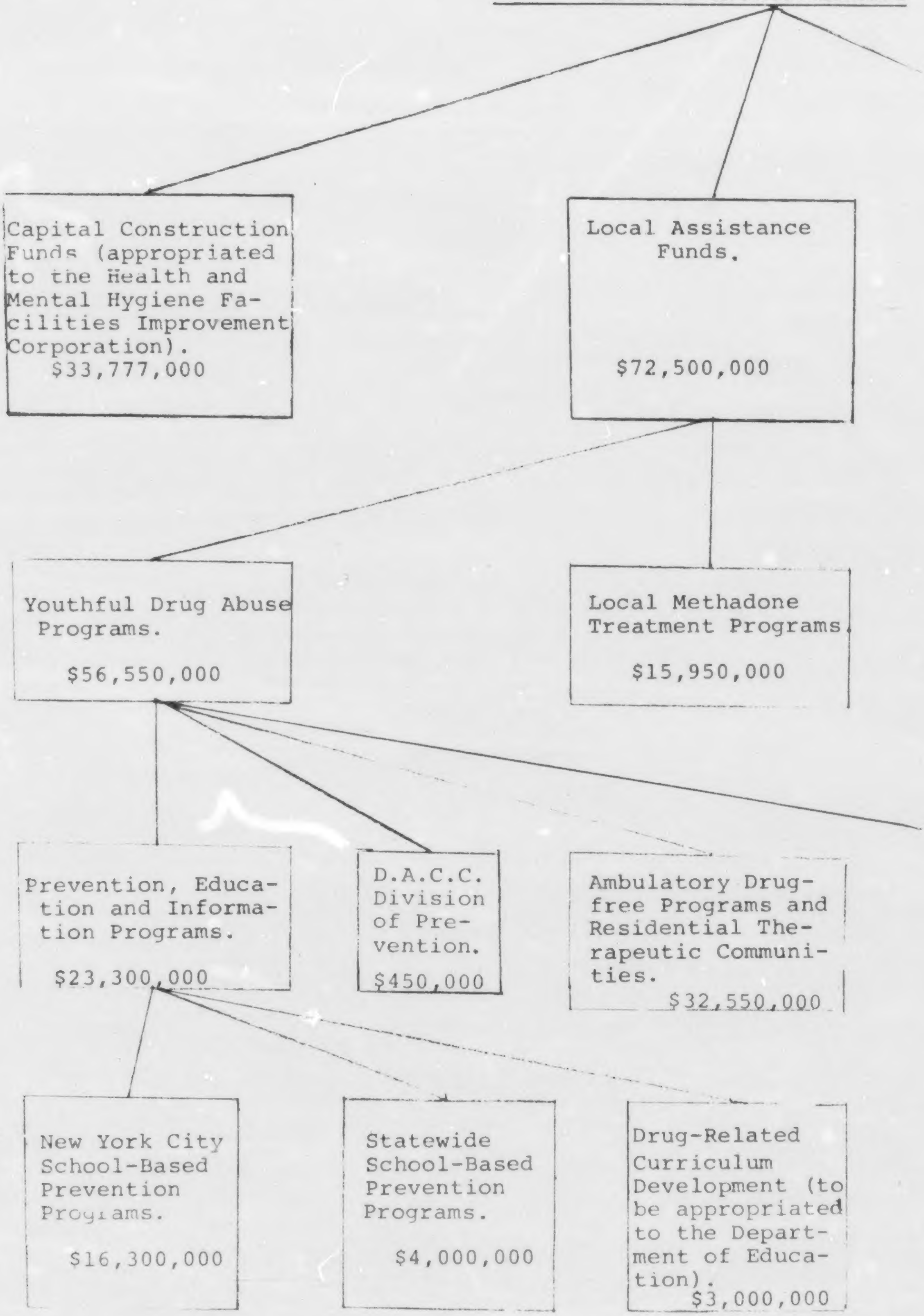
*See: Proposed New York State Controlled Substances Act and Revision of Article 220 of the Penal Law, Commission Report, Legislative Document No. 10 (1972).

**See: Employing the Rehabilitated Addict, Commission Report, Legislative Document No. 10 (1973).

***These figures do not include contract grants from the Special Action Office for Drug Abuse Prevention and the National Institute of Mental Health.

1973-74 APPROPRIATIONS



Capital Construction Funds (appropriated to the Health and Mental Hygiene Facilities Improvement Corporation). $33,777,000

Local Assistance Funds. $72,500,000

Youthful Drug Abuse Programs. $56,550,000

Local Methadone Treatment Programs. $15,950,000

Prevention, Education and Information Programs. $23,300,000

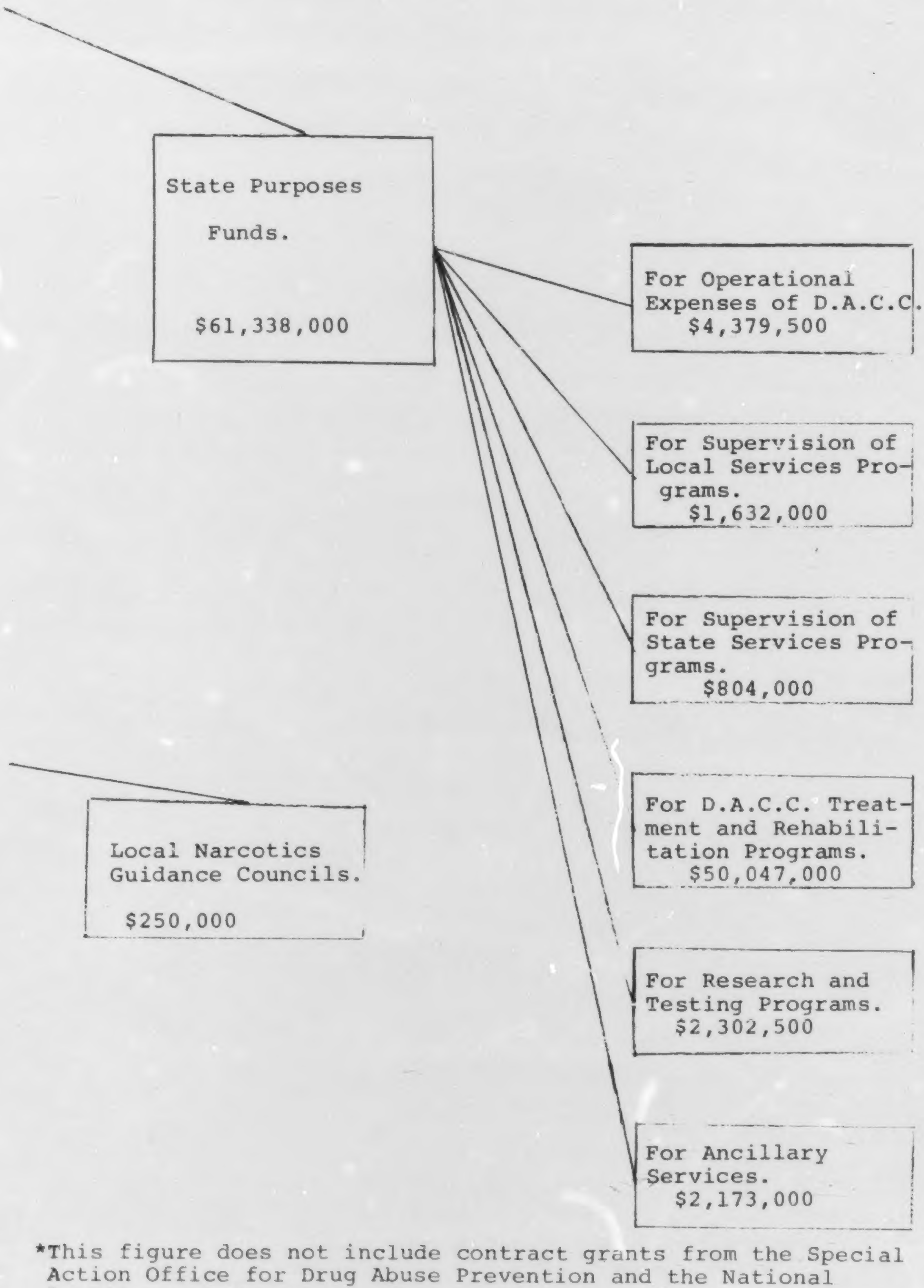
D.A.C.C. Division of Prevention. $450,000

Ambulatory Drug-free Programs and Residential Therapeutic Communities. $32,550,000

New York City School-Based Prevention Programs. $16,300,000

Statewide School-Based Prevention Programs. $4,000,000

Drug-Related Curriculum Development (to be appropriated to the Department of Education). $3,000,000 to D.A.C.C.-$167,615,000*


State Purposes Funds.
$61,338,000
For Operational Expenses of D.A.C.C.
$4,379,500
For Supervision of Local Services Programs.
$1,632,000
For Supervision of State Services Programs.
$804,000
Local Narcotics Guidance Councils.
$250,000
For D.A.C.C. Treatment and Rehabilitation Programs.
$50,047,000
For Research and Testing Programs.
$2,302,500
For Ancillary Services.
$2,173,000

*This figure does not include contract grants from the Special Action Office for Drug Abuse Prevention and the National Institute of Mental Health.

SECONDARY PREVENTION

The basic premise of secondary prevention activities is that recognition of a potential drug problem, coupled with some form of intervention, hopefully sought by the troubled individual, himself, will make the difference between abuse of drugs and abstinence from illicit drug use. At the very least, the immediate negative consequences of experimentation will be treated.

As originally conceived, crisis intervention programs were designed to provide emergency assistance to individuals experiencing difficulties in relation to drug use. Originating as "crash pads", these programs now provide medical and other assistance for such drug-related problems as overdoses, the effects produced by stimulants and hallucinogenic substances, and illnesses arising from drug impurities and dirty needles. They also provide food, clothing and shelter to drug users and others in need of such assistance.

More recently, some crisis intervention programs have expanded their activities to include measures designed to prevent substance abuse. Some programs now utilize group therapy, medical counseling for sexual, health and nutrition problems, and legal counseling. A portion of the $56 million appropriated to D.A.C.C. for its Youthful Drug Abuse Programs is expended on these activities.

Those programs which offer a variety of services designed to assist the individual to cope with his problems, whether they are drug-related or totally independent of drug use, operate on the thesis that, by doing so, drug use will become irrelevant to the client's "scene".

One New York City program which utilizes this approach is "The Door". Funded by the National Institute of Mental Health, "The Door" provides the following services: general medical services; gynecological and family-planning services; pre- and post-natal care; sex counseling; nutritional guidance; psychiatric, legal, educational and vocational counseling; drug counseling; and creative workshops. Another more generalized program is "Middle Earth" at the State University of New York at Albany.

Dr. Elizabeth McAnarney* told the Commission in Buffalo that the most usual point of entry for the youngster seeking help is his recognition of a specific medical problem In commenting upon the need for services for youth, Dr. McAnarney noted "teenagers may need a 'ticket of admission', in order to get help and a physical complaint may serve this purpose. It is well-known that even though many teenagers present to adolescent clinics with complaints such as stomach aches and headaches, the majority of youngsters under further evaluation have no evidence of organic disease, but do have many psychosocial concerns. The adolescent concerned about his own drug use may not be able to admit using drugs on the first visit to a facility, but once there for another reason on subsequent visits may be able to discuss his real concerns."**

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*Assistant Professor of Pediatrics, Psychiatry and Medicine and Director of the Adolescent Program at the University of Rochester School of Medicine.

**This approach is similar to the one first used at the Haight-Ashbury Free Medical Clinic in San Francisco.

Originally conceived as emergency assistance for drug-related problems, crisis intervention can be developed into a means of providing worthwhile services to help people, and, particularly, adolescents, with or without reference to drugs.

A further concept of secondary prevention is education for persons guilty of driving under the influence of alcohol. This concept is explored in our chapter on education.

PRIMARY PREVENTION

The goal of primary prevention is to pinpoint and correct the causative factors of drug abuse prior to the development of drug-related problems.

Many people have identified the widespread availability of drugs as a causal factor in encouraging drug abuse. Consequently, one way to prevent drug abuse is to decrease the supply of drugs available for misuse.

Overproduction of therapeutic psychoactive drugs has twice led this Commission to recommend the imposition of federal quotas on such manufacture. Moreover, a report issued in December, 1972*, the U.S. Senate Subcommittee to Investigate Juvenile Delinquency cited a number of studies to support its finding that extremely large quantities of the abused barbiturates are directly linked to overprescription by physicians. One study found that over 67% of the physicians surveyed believed that other physicians prescribed too many barbiturates.

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*See: Barbiturate Abuse in the United States, Report of the Subcommittee to Investigate Juvenile Delinquency to the Committee on the Judiciary of the United States Senate (December, 1972).

With this in mind, the Commission proposed and the Legislature and Governor enacted the New York State Controlled Substances Act, Public Health Law §§3300 et. seq.* Implementation of that Act has already resulted in a decline in the marginal medical use and prescribing of therapeutic psychoactive substances and a similar decline in the incidence of unwise patient stockpiling of such drugs.

The diversion of therapeutic psychoactive substances from legitimate channels of distribution is a second factor contributing to the availability of drugs. Prior to regulation by federal and state governments, one manufacturer of methaqualone, a dangerous depressant substance, reported that 600,000 tablets had been diverted from its warehouse. In recognition of this danger, the Controlled Substances Act requires stringent security precautions to be implemented by those who legitimately manufacture, store and dispense controlled substances.

In its report of May, 1973, the Commission recommended a number of other measures designed to curtail the supply of drugs in the illicit market. One recommendation sought a substantial increase in penalties for those in managerial positions of organizations engaged in continuing a criminal enterprise in dangerous drugs.**

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*See: Proposed New York State Controlled Substances Act and Revision of Article 220 of the Penal Law, supra.

**See: Drugs and Drug Penalties Under Review: A Documentary Study, Commission Report, Legislative Document No. 13 (1973).

A second recommendation sought federal action to impose strict scheduling restrictions on the production and distribution of methaqualone, short-acting barbiturates and other depressants and stimulants which appear to be available in quantities of supply which outweigh demand.

The Commission has maintained a close and ongoing evaluation of those drugs which are, or may become, subject to widespread abuse. In 1973, the Commission introduced a bill which sought to place methaqualone in Schedule II of the Controlled Substances Act. Prompt enactment of that bill was instrumental in curtailing the epidemic of methaqualone abuse which had begun to develop and which had been widely predicted by those working in the drug abuse field. In January, 1974, the Commission issued a report which reflected its findings in relation to fifteen psychoactive substances which had been increasingly subject to abuse.* The Commission introduced a bill designed to impose greater restrictions on the manufacture and distribution of these dangerous substances.

The approach taken by Governor Rockefeller in recommending more stringent penal provisions for drug-related offenses is yet another way to decrease the supply of drugs available for misuse. Apparently, the Governor felt that the threat of life imprisonment, or, at the least, lifetime parole, would deter individuals from trafficking in illicit drugs and thereby reduce the supply in the illicit market. The widespread publicity received by the Governor's proposals was thought to be a deterrent to drug trafficking.

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*See: A Proliferation of Drugs, Commission Report, Legislative Document No. 10 (1974).

Federal and State cooperation in enforcing laws relating to all aspects of illicit drug use, especially in regard to the importation and exportation of controlled substances, is essential to the success of efforts directed at curtailing the supply of abusable drugs. Another essential element is to put an end to police corruption, which results in quantities of seized drugs being returned to the streets.

A number of persons have identified boredom and lack of avocational activities or opportunities as one of the causative factors of drug abuse. A further cor[illegible] primary prevention is the creation of constructive altern[illegible] drug abuse which will provide the individual with greater oppo[illegible]ies for self-expression and, consequently, fewer opportunities and less desire to use drugs.

"The National Alternative Strategy" of the Drug Enforcement Administration lists a number of possible alternatives. Some of these include: a program in San Antonio which encourages young people to develop private enterprises, such as home beautification businesses, with services contracted to private citizens; a "Free University" which offers classes in ecology, yoga, transcendental meditation, nutrition, astrology, music, quilting, jewelry-making, math tutoring and transactional analysis; a program which takes under-privileged children camping for two weeks; and a program in which youngsters are paid for distributing government publications door-to-door, and for municipal maintenance work. Other alternatives include sports and recreation, arts and crafts and activities in the performing and the fine arts.

Another alternative is usually labelled "community action". This includes active participation by youth in the charitable, religious, economic and political structures of the community. Community action carries with it the corollary that numbers of young people may be involved in controversial or anti-establishment movements.

Whatever activities may be offered as alternatives to drug abuse, there appear to be two elements which, when absent, tend to frustrate effective drug abuse prevention. One is that participants will have sympathetic and suitable role models with whom they can identify and whom they can emulate. The second is peer-group involvement in policy-making. It has been well established that both biologically and cognitively youngsters mature earlier than ever before. Consequently, it is necessary for them to share in the appurtenances of power if they are not to use drugs for the purpose of indulging in fantasies of power. The Commission is concerned, however, that recreational and community service projects should be advocated on their own merits, and not solely in terms of drug abuse prevention. We believe such activities are valid without reference to drug use and should be funded accordingly.

A further concept of primary prevention concerns the problem of alcohol abuse. One causative factor of drug abuse, which was frequently mentioned by persons throughout the State, is the acknowledgement that Americans need "something" (albeit alcohol), but that children may not use other mood-altering substances. A society that not only indulges the heavy drinker, but positively ennobles him, particularly in the mass media, is facing an insuperable obstacle when it seeks to induce an individual to abstain from other forms of drug-taking behavior. Witnesses at every hearing conducted by the Commission expressed the view that this hypocritical treatment of alcohol use vis-a-vis the use of other drugs has resulted in a serious impairment of the credibility of those concerned about the entire spectrum of drug-taking.

One group of measures suggested as a means of restoring credibility* contemplates action by the Federal Communications Commission to prohibit television advertising for all alcoholic beverages, including beer and wines, action by the Federal Trade Commission to require a cautionary message, similar to that required for cigarettes, to be placed upon labels and printed advertisements for all alcoholic beverages, and action by television broadcasters to voluntarily monitor the content of their programs and to omit overindulgence in alcohol as a source of humor.

A third approach, which combines elements of primary, secondary and tertiary preventive effects, is to clarify standards of appropriate conduct subsequent to the ingestion of alcohol, and, perhaps, other mood-altering drugs.

A further concept of primary prevention relates to the role of the media in discouraging individuals from misusing drugs. Essentially, this concept is composed of several related approaches. One approach is to regulate for truthfulness advertisements for pharmaceutical products. Suggestions have also been made to this Commission regarding regulation of the frequency and timing of drug commercials on television.

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* See, for example, 1973 Assembly Bill A.10686.

A more dubious approach is to utilize scare tactics to dissuade individuals from drug misuse. However, suggestions relating to counter-commercials, as well as cautionary notices on alcohol products may have merit. The subject of the media's role in drug abuse prevention will be dealt with more fully in our chapter on the media.

Education of children, adults and professionals concerning drugs and drug abuse is the most widely implemented concept of drug abuse prevention. Essentially, education takes two forms: scare tactics and information. Both forms are utilized on a mass appeal basis and on an individualized basis to children and adults in relation to drugs. Education includes course instruction, counter-peer group pressure, speakers, pamphlets, films and other media devices to present its message.

The concept of individual education as a preventive measure is fully developed in our chapter on education. The concept of mass information as a preventive measure is analyzed in our chapter on the media.

EVALUATION OF ALTERNATIVES TO DRUG ABUSE

Constructive activity, in terms of satisfactory education, rewarding employment and wholesome recreation, clearly play a role in preventing the abuse of chemical substances. With increasing leisure time, affluence, mobility and sophistication, young people today are more than ever in need of activities to occupy their spare time. The competitive aspects of organized athletic programs have not been as attractive to as many "at risk" youngsters as once may have been anticipated. The creation of teen-age drop-in centers, particularly in Onandaga County (Syracuse area), has, at least partially, tended to fill this need. Unlike their European counterparts, these drop-in centers do not tolerate the use of intoxicants on the premises, and they do seem to be better organized than centers visited by the Commission in Hamburg and Amsterdam. The centers have been supervised by the YMCA; however, their policies and administration are as largely a function of student participation and planning as they are of adult involvement. Indeed, their members have testified that the establishment and success of such centers depend upon student expressions of need and upon students assuming responsible leadership roles.

Youngsters report that the most attractive feature of these centers, such as the Fayetteville-Manlius Regional Teen Center, Inc. and the Liverpool Youth Center, Inc., is that in no way to they call attention to drug abuse prevention techniques or concepts (except for funding purposes). They employ quite a different approach. They believe that a singularly important manifestation of our modern social upheaval is the emergence of a true youth culture. They see this youth culture as pessimistic, negativistic, undisciplined and disillusioned. They provide an alternative to dropping out: dropping in. Available are such activities as:

1. Simple relaxation in a non-institutionalized and non-threatening atmosphere.
2. Self government of the center.
3. Movies.
4. Sports (organized along more informal lines than is customary).

5. Trips and outings.
6. Guest speakers.
7. Fund raising projects.
8. Handicrafts.
9. Retreats for small group problem-solving.
10. Employment opportunities.
11. Hobbies.
12. Drama and music.

Not surprisingly, the teen-agers have reinvented, for themselves, the community center, and made it their own. Surprisingly, this sort of enterprise, the most common and essential recreational need of any civilized community, must justify itself in terms of something called "drug abuse prevention". The annual budget of the Liverpool Center is $35,000, of which $2,000 comes from the Narcotics Guidance Council and the rest from the participating townships and public subscription. The Fayetteville-Manlius Center operates on an annual budget of $30,000 (serving 400 to 500 students, ages 14 to 20). Half their budget is made up of public contributions; the other half is provided by the Narcotics Guidance Council.

Rev. Randy Riggs, who is Chairman of the Fayetteville-Manlius Center spoke with the Commission staff about the irrationality of having to justify a community center in terms of drug abuse prevention. He urged that recreational centers be funded purely on the basis of the fact that they are good, in and of themselves. "While no one would be surprised if such centers contributed to a climate in which drug taking and other forms of unacceptable conduct were less likely to occur, the strength of any teen center is precisely its avoidance of such a specific goal," he said.

EVALUATION OF OTHER PRIMARY PREVENTION CONCEPTS

When the National Commission on Marihuana and Drug Abuse issed its second report in March of 1973, many were struck by its recommendation in favor of a moratorium on all primary drug abuse prevention efforts relating to education, until programs then in existence could be fully evaluated. In response to this recommendation, those involved in the prevention field immediately requested additional funds for "evaluation". Conspicuously absent from these requests was any definition of the term, evaluation. The complaint of the YDA programs has always been a lack of continuous funding, which results in staff-turnover. However, when members of the Legislature continually request data on the indicia of success of YDA and other prevention programs, they are told that there is no way to prove a negative; i.e., how many youngsters are not now abusing drugs and alcohol as a result of prevention efforts. Although some studies have been made regarding student attitudes and truancy, abstinence or moderation studies are not possible. Because the drug picture is constantly changing, with cocaine emerging as a heroin substitute, due to the shortage of heroin on the street, and with alcohol becoming a primary drug of addiction among the young, we find that it is safe to say that many so-called prevention efforts have succeeded at preventing nothing of consequence in those areas in which they operate.

Since so much of the toll taken by drugs and alcohol in New York State is levied in New York City, and since New York City receives $16.3 million each year for school-based prevention programs (as opposed to $4 million for the rest of the rest of the state), we asked the New York City Department of Mental Health and Mental Retardation Services to help us analyze the New York City programs. Here, in part, is their analysis:

The drug education classes, they said, present the students with information through lectures and films; the Peer Group Programs selects students for training in group process techniques with which they are to educate their peers; the SPARK program, in high schools, utilizes integrated teams of school personnel and drug education specialists.

The Department found the drug education classes to be "neither comprehensive nor effective. In fact, recent studies have indicated that this type of drug education may lead to drug experimentation rather than its elimination. The selection by the school of participants for the Peer Group Program reportedly has resulted in the creation of an elite group within the school, and failed to reach the drug-prone students."*

Moreover, although the Department points out that the definitional weakness of the SPARK program is that it cannot reach those already out of school, it is successful only to the extent that emphasis is placed on "reaching the student with academic or family problems." Recognizing the inadequacy of a drug program to perform such far reaching functions, the Department calls for greater access to mental health services within the educational system and between the schools and community mental health facilities.

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*See, also, Andrew Bern, Glenn Gorlitsky, Drug Education Study; Student Attitudes and Perceptions in Grades Seven through Twelve Concerning Existing Drug Education Programs and Substance Abuse (Port Jefferson, N.Y. 1971).

Similarly, the Executive Director of the New York City Board of Education's Division of High Schools, had this to say:

> I find a tremendous proliferation of agencies developing in recent years committed to provide services for the same children. We have SPARK, Peer Group, State Supervisors, School Health Aid Departments, Guidance Counselors, etc. More and more it becomes obvious that drug, drink or other forms of unfortunate behavior are reflections of inner problems of the young people involved. As a result all the drug groups begin offering guidance services. Some of them turn to special techniques of putting a youngster on a 'stand' and subjecting him to grueling questions. Others try other alleged helpful techniques without any background in training or experience to control such activities. Each drug group becomes a vested interest trying to prove that it is solving the problem, and each moves somewhat irresponsibly into areas for which it is not prepared.
>
> I would suggest a new approach to the entire matter of drugs and liquor abuse. It seems to me that staff should be made available in every elementary school to whom troubled children could be referred for intensive analysis and assistance. It seems to me that treating the students or giving information about drugs never really tackles the inner factors of poor adjustment which may lead to the involvement. If we organized these units around the concept of guidance and significant assistance, then other personnel could be used to provide any special information called for by the special needs of the youngsters.
>
> Only a broad general approach to the problem of troubled children with trained professional personnel to do something about these inner troubles can we hope to move toward an eradication of the problem of drugs. The rest is simply wasted effort.

The Area Guidance Consultant for BOCES II in Patchogue, Long Island, agrees. Pressing for the availability of more professionally trained guidance counselors to deal with the full range of student problems, he testified:

"Employing drug counselors or drug educators in the schools is divisive and costly."

Testifying to the failure of school efforts to raise the level of student health care and health education, generally, throughout the southern portion of the state, the Director of the Drug Treatment and Education Center, North Shore University Hospital in Manhasset, Long Island, stated:

"Drug education has been a dismal, dismal failure. It is a sham that should no longer be tolerated by the schools. It is a sham that was created at the height of a crisis; created in a climate of hysteria, fear, emotionalism and...expediency.

"Drug abuse...is a health problem and consequently drug abuse prevention efforts must be an inherent part of a dynamic, high priority health education system."

The concept that drug abuse prevention is inescapably part of a much larger picture has led many drug educators in the state to testify that what they are actually doing is not trying to prevent drug abuse, per se, but, rather, attempting to inculcate values or meet basic student needs. The question of how successful attempts to inculcate values have been is dealt with extensively in our chapter on education. The finding is that such efforts have been futile at best and counterproductive at worst. Attempts to meet basic student needs are not "drug abuse prevention", they are simply attempts to meet basic student needs, often by superficial means and with poorly trained personnel.

Onondaga County may serve as an example which verified the situation in southern New York. Although the Narcotics Guidance

Councils spend some of their money to partially fund community centers, the Onondaga-Madison County Preventive Drug Education Program serves a separate function. According to testimony of its Director, 20 school districts claimed 39,756 one-to-one counseling sessions and 14,418 group counseling sessions for the school year 1972-73. An estimated 142,495 individuals were counseled. Group counseling was rated as 90% effective and one-to-one counseling was rated as 89% effective. Unfortunately, the counselors rated their own effectiveness, and what was meant by "effectiveness" was never spelled out. This is particularly significant since the subject of drugs was not even remotely connected with six out of seven of the counseling sessions. Thus, it is claimed that drug counselors, rather than trained guidance counselors, have been seeing over one hundred thousand students per year in Onondaga and Madison Counties for the last three years to talk about problems other than drugs.

While it might be argued that some attention to student problems is better than no attention at all, we believe that if there is a need for more trained guidance counselors to handle student problems, the bulk of which are non-drug related, then guidance counselors should be provided in increased numbers, instead of drug counselors, of uncertain professional training, who try to offer assistance regarding other matters under the rubric of drug abuse prevention.

Recognizing that the problem is not drugs, but the needs of people, the City of Syracuse-County of Onondaga Drug Abuse Commission has submitted testimony that "consideration should be given to allowing drug-funded programs to offer services to a broader clientele than strictly drug abusers...Efforts at preventing drug abuse should also be concerned with efforts to prevent other types of deviant or aberrant behavior."

We agree with the conclusion, but we cannot understand the rationale of using the rubric of drug abuse prevention to include everything under the sun. If the goal is not drug abuse prevention, as most experts testify it cannot be, but rather to increase the availability of non-drug related counseling, health and mental health services, because six out of seven of the clients are not only potential drug abusers, but may be at risk with regard to alcohol or school failure or social inadequacy or delinquency or family problems, then what is needed is less drug nomenclature in the establishment of funding priorities, and more straightforward approaches to the entire range of childhood and adolescent needs.

To summarize via the testimony of the Director of a school-based prevention program in Queens:

1. Drug education has been a "dismal failure", he stated.

2. Current efforts center about abstract techniques for raising the self-esteem of children.

3. But with all of their emphasis on "peer groups" and understanding "feelings", school based drug programs are not able to deal with the most fundamental problems of learning and of social adjustment. Said the Director:

> A child with an undiagnosed perceptual problem who experiences constant frustration and failure in his efforts to learn to read, is more likely to engage in non-constructive behavior to

cover up his feelings of inadequacy. As he gets further behind academically, he may feel increasingly alienated from and unaccepted by his peers, and under constant pressure from the adults in his environment. The drug culture is totally accepting of all inadequacies. Once on drugs, it does not matter if one cannot read, cannot make it with girls, cannot hold a job. The drug culture, then, can be particularly attractive to these "chronic losers".

Questions regarding the efficacy of prevention* efforts funded under the Youthful Drug Abuse Program, have been called to the attention of the Drug Abuse Control Commission by this Commission, as well as by others. Indeed, when asked at the New York City hearing whether prevention should more appropriately be handled by professionals and agencies which deal with health, mental health and child care, the Chairman of the Drug Abuse Control Commission said:

"Basically, I cannot disagree with you. The practicalities of the situation, though, make such an approach highly unlikely; in this sense: If we are to address the social ills or the contributing factors, whether it's emotional well being...physical health, and what have you, in general, and you do not identify a cause on which you can hang your hat to spend money, then you're going to have nothing."

We believe that a rational state policy dictates precisely the opposite approach. If the YDA Programs, themselves, admit that their efforts, however well-intentioned, have not yielded demonstrable results and that there is a greater need for more professional health and mental health services to children than such programs can provide, then we believe that the state should reassign a significant portion of the funds presently used for these prevention programs to such other pressing social concerns, the relief of which are likely to result at least in some deterrence of social deviancy. We do not doubt that an occasional drug prevention program may now provide counseling or referral to a troubled youngster. In terms of state policy, however, these random efforts bear little relation to the broader health and mental health problems at hand or the amounts of money being spent.

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*as opposed to treatment

Just how the state should spend at least a substantial portion of the money now being devoted to drug abuse prevention is the subject of our chapter on education.

THE GOAL OF DRUG ABUSE PREVENTION

Much of the discussion regarding purposes of efforts aimed at preventing drug and alcohol abuse has centered about the question of whether either abstinence, on the one hand, or caution in experimentation, on the other, ought to be the goal of prevention efforts. We believe that such discussions misstate the issue and are counterproductive. If abstinence becomes the goal of substance abuse prevention, then the widespread experimentation by children, particularly with alcohol, pills and marihuana, will further tend to destroy the credibility of prevention efforts. On the other hand, if caution is the desired goal, and if experimentation is tolerated, *ab initio*, we believe that efforts relating to prevention will have the effect of creating a climate of permissiveness and will, in fact encourage drug use.

Because, as we document in our chapter on education, we cannot, as a society, effectively discourage drug use directly, we believe that the most suitable goal of substance abuse prevention is to help the child develop, particularly along scholastic and vocational lines, the best level of functioning of which he is capable, diligently caring for his health and mental health needs along the way. In other words, we view drug abuse prevention as helping to redirect the child from a continuum to failure towards a continuum to achievement. To the extent this can be accomplished, we believe that experimentation and abuse of mood-altering substances will be curtailed because they will no longer be relevant to the needs of the child.

We are quite skeptical, therefore, not only of current prevention efforts, per se, but also of those techniques couched in terms of teaching the child to accept himself. We question whether any child should be tutored to accept failing, particularly when it is so often our failure to help him develop meaningful scholastic and vocational skills which may be the underlying cause.

As we have said before, we cannot prove that our thesis will work, but in light of the nature of the problem of substance abuse in our state and in light of the failure of efforts labeled "prevention", we believe that the only rational course open is to seek to make substance experimentation and abuse irrelevant to the needs of the child, by meeting those needs: practically, effectively, and wholeheartedly.

CHAPTER III

EDUCATION: SCALING THE PROBLEM DOWN TO SIZE

"Can the man whose picture you see on television see you? Then how does he know that what he is selling is good for you?"

Rose Daniels, Nurse-Teacher

INFORMATION ABOUT DRUGS

Mass education is a collectivist solution to the problem of individual learning. The presentation of information, the analysis of the structure of thought, and the formulation of concepts having to do with shared cultural experiences are the three fundamentals of public education. Foremost, however, is a belief that the presentation of information will result in more rational behavior and that rational behavior will be desirable behavior.

The central problem regarding information about drugs is that it is all controversial. For a number of years, opposing camps have debated the question of the harmfulness of marihuana.* Most people do not quite believe that marihuana is not addicting; most people do not believe that marihuana is harmless, and most people do believe that marihuana is a stepping-stone to more serious forms of drug use. Others insist that marihuana is not addicting;

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*See: Marihuana, Commission Report, 1970, Legislative Document No. 8.

that when it contains low concentrations of active ingredients, it is harmless; and that while marihuana experimentation does precede other drug use, so does alcohol experimentation. Moreover, it is argued that most people who use marihuana ultimately lose interest and stop. They do not proceed to more dangerous drugs.* The stepping-stone theory demonstrates the fallacy of logic known as post hoc, ergo propter hoc. That so many people subscribe to such a fallacy may be a comment on the efficacy of educational efforts relating to the structure of thinking.

To complicate the marihuana picture, however, there are additional controversies. Among the activist left, there are some who believe that heavy use of marihuana can lead to the passivity of those who should be in the forefront of fighting for social change; others believe that marihuana use represents the freedom of having one's own drug of choice; and, of course, the alcohol comparison is argued both ways: why turn one problem into two; or why not, since different people are involved?

To complicate the picture still further, the question of legalizing the use of marihuana has now become one of "decriminalization", which would result in legality without effective controls. The underlying assumptions in this position, if applied to drug manufacturers at large, would allow them to distribute vast amounts of other drugs without meaningful regulation. The distinction is, apparently, that a hundred thousand small-scale user-sellers of marihuana, without quality controls, can do less harm than one large distributor of a tranquilizer, who cannot account for the quality or whereabouts of a hundred thousand pills. The distinction is elusive, if not to say totally without logic.*

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*National Commission on Marihuana and Drug Abuse, Report, March, 1972.

The rehearsal of the marihuana controversy is used here to illustrate the problem of making the dissemination of information the fulcrum of drug abuse prevention. Lest it be said that marihuana represents a special case, consider a recent development in the enforcement of penalties relating to the possession and sale of cocaine.

Cocaine is a stimulant drug with euphorogenic properties. Most authorities believe that prolonged use can lead to emotional dependence, paranoid ideation, secondary tissue-damage and, ultimately, psychosis and death. Because the user cannot associate growing but unverifiable suspicions with his cocaine use, there is always a possibility that he may become violent in a situation he feels is threatening, but which may be objectively neutral.
For approximately 50 years, cocaine has been regulated under the rubric of "narcotics". Recently, cocaine use has increased in New York State. Following one major arrest, a prominent defense attorney was able to muster a series of eight affidavits from leading drug experts who insisted that cocaine is erroneously listed as a narcotic, not only because it is not physically addicting, but also because it is not really a problem. However, each

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*Dr. Brill stands by his support of the decriminalization proposal of the National Commission on Marihuana and Drug Abuse. He believes that marihuana penalties should pertain for major traffickers and that marihuana is less harmful than scheduled depressants.

of their comments was couched in terms which, to the careful reader, implied that cocaine is not a problem when it is scarce. Nevertheless, word has apparently permeated the marginal world of drug users and students that cocaine has now been given a clean bill of health by people they can trust.

Heroin, the drug most associated with pejoratives, was, itself, recently the subject of a series of articles in *The New Yorker* which questioned whether it is the drug that is addicting, or whether it is society's expectations of the results of heroin use which conditions people to be addicted, or whether there are simply addictive personalities, one of whom any individual user may not be.

Because young people do not necessarily make a virtue of avoiding danger, conflicts about the consequences of drug use among authorities, and those who hold themselves out as authorities, tend to increase risk-taking among the young. If material is presented to show the harmfulness of drugs, it may be discounted because controversies are well-known, or even because everything said by establishment figures is today discounted. It may also be discounted, because the experience of the child, however limited or misleading, may suggest to him that the toll of drug use may be more easily bypassed than in fact is the case. If material is presented objectively, leaving the youngster to make his own choice, those who might never have considered taking drugs will suddenly see a veritable wonderland of potentially attractive choices among drugs. They may take some drugs which are not as harmful as others, which is rational, but which may not be desirable.*

In the event that drug education is fraudulent or misleading, which much of it has been, credibility may be lost regarding many more items on the educational calendar than drugs.

The response of educators and others in the drug abuse prevention field to these findings, which are now widely known, has been to attempt a shift away from the informational aspect of drug education, although the law presently requires such an approach.** The present approach is verbalized as "values clarification", or more ambitiously, "basic attitudinal and behavioral changes leading to the clarification of an individual's goals in life."***

Helping children clarify their own values and goals may be particularly difficult when neither teachers nor society-at-large have clearly defined values and goals of their own. With

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*"Outcomes of Drug Education: Four Case Studies," Pediatrics, Vol. 52, No. 2, August 1973. "Drug Education is Linked to Use," New York Times, December 3, 1972. Also, Second Report of the National Commission on Marihuana and Drug Abuse, March 1973.

**Education Law Section 804-a.

***Testimony of the Director of a Queens School-Based Drug Abuse Prevention Program.

regard to drugs, for example, teachers appear to be divided or individually undecided as to whether drug abuse should be defined as any non-therapeutic use of mood-altering substances by children, or whether drug abuse should refer only to the use of substances to such an extent that the capacity of the child to function within the usual parameters of his ability will be impaired. Most of the materials disseminated to children are ambiguous. Their thrust is that the child should decide, and that drug education should be a process of helping the child understand how to make the right decision. Having failed to prevent substance abuse by telling children such conduct is unacceptable, the effort now is to help them see something like that for themselves, without previously determining whether the ultimate goal is abstinence or cautious use of drugs. Moreover, nowhere are the goals with regard to alcohol use spelled out or related to goals for other forms of substance use.

An examination of some of the learning materials and lesson goals of one widely distributed model approach to "values clarification" may serve to indicate the futility of this tactic.*

The goals are expressed as follows:

> To legitimize feelings and their expression in the classroom; to make the teacher accountable; to give students skills in coping, decision making and value clarification; to give the students the skills and self-confidence to make demands that may effectively change the structure of the educational system (or the world).

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*Materials provided by a Brooklyn School-Based Prevention Program.

Would that these were all gifts within the province of the teaching profession to give! Has this statement the remotest connection to the causes of drug abuse? The Schenectady Family and Child Service sees the reality of families afflicted by substance abuse:

> The families had never sought help with their own long standing problems. The children had exhibited consistent and repeated problems in school almost from the beginning of their entrance into school. The school problems usually became more serious with increased age beginning with poor performance, and by the time they reached Junior and Senior high school they had coupled poor school performance with behavior problems, truancy, etc. All had a bad school performance record from their earliest days in school.

A society which teaches children that they can "effectively change...the world", but does not attend to the reasons for their inability to read or write or calculate, arguably needs some values clarification of its own.

There are those who continue to maintain that some device in the teaching world can be found to manipulate children out of drug use or at least out of serious substance abuse. Let us examine closely those devices.

1. Marvin Finds A Friend. A number of booklets have been put together as aids in developing certain attitudes and skills among children. The formal classroom setting is usually relaxed, and an attempt is made to turn the lesson into a "rap session". Marvin Finds A Friend sets as its goal "to explore the fact that feelings of incompleteness may result from a lack of peer relationships. It should be stressed that adults in the child's world may help him resolve these feelings of loneliness".

Estrangement from parents, disapproval of parental conduct and feelings of rejection are typical of deviant youth. We believe that to suggest to isolated youngsters who cannot form satisfactory peer relationships that they seek the companionship of older persons, when none are available, or when the only ones available may be a harmful influence, can result in despair and the seeking out of quite the wrong older role models. Clearly what is being evaded here is the issue of why the peer relationships of the youngster are unsatisfactory: Is he regarded as stupid? Is she regarded as fat? Is his family, or lack of one, looked down upon? What are his learning problems with regard to games, sports and schoolwork? How is her muscular coordination? Are there undetected allergies? Asthma? Is there an emotional or adjustment problem which surfaces only among peers? Instead of ruling out real problems, the teacher fantasizes, in this exercise, solutions which do not exist.

2. Marvin's Hurt Feelings. In this exercise, Marvin becomes the model for children with "hurt feelings." As in most academic situations, the cause of the hurt feelings is not a black eye, not a beating by a parent, not a failing grade in school nor a rejection by playmates; the cause of hurt feelings is a drawing discarded in error by a family member. This lesson seems to say to the child that older people who do things that hurt the feelings of youngsters are not ill-intentioned, they are really just making small mistakes. Therefore, to become angry about hurt feelings does their elders an injustice. It is this Commission's conclusion that when child neglect and child abuse are an everyday reality for some children, such a lesson contributes, however

unintentionally, to a further lowering of the child's self-esteem, and would not help prevent substance abuse. On the contrary, it might encourage such behavior.

3. Marvin's Mistake. This talking point involves medications in the home. The aim is to help the child understand that medication should be used only for the purpose intended. What is presented? Marvin feeds aspirin to a cat, which gets sick. What is taught here is that no reflection on the use of barbiturates or other mood-altering substances by parents is permissible. Inappropriate use of medication means feeding aspirin to a cat!

We could go on to analyze scores of pamphlets and teaching materials as fatuous as the above; however, we believe the point is clear: It is impossible to teach values clarification when the material presented itself contains well-intentioned but highly confused notions of what attitudes in children precede substance abuse. Indeed, we would go much further. The concept that the manipulation of attitudes can change the directions of childhood behavior already strongly influenced by failure and unresolved conflicts is a manifestation of unwillingness to confront basic issues. Children do not "learn" values. They develop values based upon life experiences. If school represents a useless exercise at best and a framework for failure at worst, then one hour each day of "values clarification" will probably result in more harm to the child than good. Why should valuable school time, valuable professional personnel and valuable education dollars be taken up with misleading nonsense, when the children are so plainly in need of help with their reading, their math, and their perceptual, physical and emotional problems?

We said at the outset that education is comprised of three principal elements: information, cultural heritage and the structure of thinking. The isolation of drug abuse as a subject to be dealt with in the school curriculum, we believe, is not consistent with one of these elements: the structure of thinking. Mood-altering substances are subjects of only one form of exploitation in our consumer economy. There are thousands of useless, shoddy and harmful products offered for sale, both legally and illegally, each day to us all. Paints, aerosols, insecticides, tobacco, vitamins, household appliances, breakfast foods and food additives are but a short list of products recently brought under scrutiny by consumer groups. Advertising, opinion sampling, attitude manipulation and political propagandizing, both overt and _sub silentio_, confront us constantly. The Commission finds that although the educational system cannot ignore drug abuse and alcohol abuse when attempting to educate our children, it should incorporate references to substance abuse in that portion of the educational framework which deals with the structure of thinking.

We believe that classrooms are bad places in which to try to manipulate values having to do with substance abuse. We reject the theory that a significant cause of substance abuse is "peer-group pressure". We believe that values cannot be manipulated either by the schools or by peers, that they are formed as a result of a child's genuine experiences, and that peer-group pressure serves to reenforce or undercut only those values already developed. A child whose health has been neglected cannot have very much respect for his body. A child emotionally and educationally short-changed cannot have very much respect for his mind. To say that such a child's acceptance of drugs from a companion is a form of succumbing to peer-group pressure is not merely to state an oversimplification; it is a way of rhetorically isolating substance abuse as a phenomenon of children for whose actions society is not causally responsible.

On the other hand, we believe that the structure of rational thought is and always has been a valid element in the learning process. Once learned, techniques of thought can be applied to a variety of situations in which claims are made for consumer goods and services, political theories and social policies. While drug taking may not be a completely rational process to be deterred by rational arguments, the greater availability of reason, without necessarily any specific reference to drugs, would be a good in and of itself.

If logic, the recognition of persuasion techniques, and the structure of sound thinking may lead to better citizenship and, perhaps, better sales resistance, the improbability of success in teaching such matters cannot be underestimated, when children most susceptible to their own folly have difficulty with abstract thinking. To remedy that difficulty, the underlying problems of educational failure must be addressed: in the school, in the home and in agencies of the community. There is nothing wrong and, we suspect, a great deal right, with attempting to make a student a better logician, provided it is understood that without skills in the use of language and other symbols there is no foundation for the development of a thinking structure at all.

The Fleischmann Commission Report offered four recommendations specifically dealing with techniques of intervening in the cases of students who may have learning disabilities. It is well known that between the ages of one and five most children do not receive sufficient attention with specific regard to their learning growth and development. The entrance of a child into the school system presents an occasion for detecting, assessing and treating conditions which may impede the learning process. The Fleischmann Commission recommendations were (in part):

1. To help identify the more than 200,000 children with suspected learning disabilities not presently receiving any special services, a basic and simple screening test should be administered to every child upon entry to school, public or private. State law already requires such tests for vision and hearing; we recommend additional tests for speech and motor coordination. These four tests should be administered to all students annually through Grade 4, again at Grade 7 and upon entry to high school.

2. To safeguard against incomplete or incorrect diagnosis of children with suspected handicaps, all children who do not pass the tests in the screening battery, as well as children located by parents, physicians, and public and private institutions other than schools, should be referred to multidisciplinary diagnostic teams composed of a pediatrician, psychologist, social worker, teacher and paraprofessional tester for thorough diagnosis. Each team should have access to an ophthalmologist, audiologist, psychiatrist and neurologist as well.

3. Teacher-training institutions in the state should prepare all prospective classroom teachers in the rudiments of elementary

diagnosis of mildly handicapped children and in ways to assist these children in regular classrooms.

4. The state should also subsidize a special program to re-educate practicing classroom teachers as special teachers for the increased numbers of handicapped children requiring special educational services.

The Commission to Evaluate the Drug Laws has received accounts of intervention on behalf of students who may have learning impediments at two stages of their school careers: the early grades and the grades included in junior and senior high school. We believe that these experiments are worthy of wide-scale replication throughout the state, and we find that as a matter of state policy such procedures would be of sufficient benefit to young people and their families to act as a deterrent to later deviancy among children.

INTERVENTION
in the
EARLY SCHOOL YEARS

One of the problems endemic to reports such as this (and even to the Fleischmann Report) is that no matter how well researched the findings, they always appear to be speculative and idealistic, rather than practical and result-oriented. There is, however, for our present purposes, a specific series of experiments which have been reported and which can serve as the touchstone of sound detection and treatment of learning impediments in the early school years. We present the results of these experiments not dogmatically as approaches which may not be modified, but as amplification of our thesis: (1) that school failure results in emotional decompensation; (2) that such decompensation can lead to a variety of forms of deviant behavior; (3) that emotional decompensation is predictable in individual children based upon the discovery of learning disabilities -- and (4) that learning disabilities, which can have later cumulative effects, are correctable in the earlier years with the consequence of enormous savings within the school system and to the state as a whole.

In 1969, a school-based program for the prevention of learning failure and its emotional and behavioral consequences was initiated by the Learning Disorders Unit of New York University Medical School with the cooperation of parents, faculty, and administration of a public school on the lower East Side of New York City.* This preventive program has been functioning in P.S. 116 since 1969 and has been further expanded into the first grades of three other public schools in the same area, has been modified for use in the kindergarten grades, and has been extended to a "Readiness Nursery" for preschool children.

The initial experiment involved a total of 168 children, 86 of whom were in the first grade of 1969-70 and 82 in the first grade of 1970-71.** These children were examined individually psychiatrically, neurologically, perceptually, psychologically, and educationally. The children ranged in age from 5 years, 7 months to 7 years, 8 months, with the median in the 6 year-6th

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*"Profile of A First Grade", Silver and Hagin, 1972; "Beyond Consultation: A Program for Preventive Psychiatry", Silver, Hagin, Kreeger and Scully, 1973.

**All first grade children were included in the experiment.

month - 7 year - 0 month range. They were 79 percent white, 12 percent black, and 9 percent oriental; they came from a wide range of socioeconomic and cultural backgrounds. Spanish was spoken in the homes of 23 percent. Their overall intellectual functioning, as measured by the Wechsler Preschool and Primary Scale, fell roughly within the average distribution curve.

On psychiatric examination, 12 percent of the total group already had symptoms suggesting emotional decompensation (especially exaggerated fears), and 25 percent were considered well-adjusted. The remaining two-thirds exhibited mild and moderate symptoms which indicated emotional stress, compensated but vulnerable. Eighty to 90 percent could distinguish reality from fantasy; however, between 40 and 50 percent had either poor impulse control, or other specific problems. Individual neurological signs were found to be minimal among 44 percent, mild among 34 percent, moderate among 14 percent, and severe among 7 percent.

As a result of testing, 29 children of the 1969-70 group and 27 from the 1970-71 group were selected to receive training based upon the deviations uncovered. The criteria for selection were the presence of perceptual deviations in spatial and temporal organization, evidence that cerebral dominance for language was not yet established, with or without deviations in praxic ability, and deviations in fine motor coordination. The intervention group was drawn from all ages, all ethnic backgrounds, and all socioeconomic groups. They tended to cluster in the lower socioeconomic groups, and all but 7 of the 56 were considered to have some degree of psychiatric impairment. The intervention group numbered approximately one third of all children in their class.

The program of detection and intervention has been functioning for almost four years in P.S. 116; it is in its second year at P.S. 61 and in its first year at P.S. 188. Original first graders are now completing their fourth grade. Of the original group remaining (34 children), three still require help.

In the fall of 1969, the oral reading scores of the children who were being helped clustered in the lowest segment of the class. By spring of 1970, the distribution of oral reading scores for the intervention group resembled that of the non-intervention group, with a median of 1.4 in the classroom group as contrasted with 1.3 for the intervention group. By the spring of 1971, when the intervention class was in second grade, the reading scores of the intervention group were close to those of their non-intervention classmates, with a median of 2.3 for intervention, versus 3.0 for non-intervention, mean score of 2.6 for intervention, 3.1 for non-intervention.

The intervention group scored better than a separate control group of similar students in which no effort had been made to screen for learning disabilities.

By the fourth grade, advancement of the intervention group was similar to advancement of the non-intervention group. However, of the total class, approximately 100 children, 16 were still reading below fourth grade in the Spring of 1973. Of these 16, eight were not in the school at the time of the original testing in 1969; one child had been refused permission for testing by his family; three children were retained from the preceding class. Of the remaining four, two children remained in treatment in the intervention group and two had been missed by the original screening and were not in the intervention group.

Most significant, perhaps, were that there were individual children with low intellectual functioning as measured by standardized tests who did surprisingly well. A girl with an I.Q. of 60 went from 1.2 in the first grade to 3.2 by the time she reached third grade -- or perfectly normal progress. Another girl with an I.Q. of 70 went to grade 4.4 in reading at the end of the fourth grade. A boy nearly six, diagnosed as hyperkinetic, was carefully trained with regard to very poor performance, and at the end of the fourth grade behaves normally and reads at a 5.1 level.*

The technique of intervention used in this experiment was to provide schools with services for remediation of defects in resource rooms manned cooperatively by the N.Y.U. unit and by New York City Board of Education personnel trained in their methods and in accepted techniques for working with the emotional and social needs of children and parents. The N.Y.U. unit provided continued training and supervision for teachers in the schools other than those directly involved in the program. Diagnostic and treatment functions were conducted primarily within the schools, and the N.Y.U. Medical Center was reserved for only such study as could not be performed in the schools. Thus, the program does not wait for referrals of children who have already failed; it detects those who are likely to fail and intervenes to correct their vulnerability.

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*No hyperkinetic child has been treated with drugs in these experiments. "We get our results in other ways," Dr. Silver told the Commission.

The experimenters found that correction of the perceptual defects detected in children must precede the teaching of reading. The hypothesis was confirmed that perceptual defects could be corrected by direct stimulation, through educational techniques,* of deficit areas, that those children responding to specific perceptual stimulation would improve in reading and in reading comprehension, and that, parenthetically, clear-cut cerebral dominance for language accompanied these changes. With this background in clinical study and educational experimentation, a program of consultation was initiated in the schools of the lower East Side of Manhattan. Here children already in difficulty were referred by the schools; the uniqueness of this program, however, was that the N.Y.U. unit supervised the teaching of these children by their own teachers in their own schools, over the period of the academic year. With this procedure, approximately 90 teachers in the lower East Side were introduced to their approach, and while many are no longer teaching in the same catchment area, those who remain form the nucleus of present preventive programs; and it is they who work in the resource rooms established in each school.

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*Teaching sessions occupy twenty minutes in the resource room three times a week. The classroom teacher is also involved in the program.

Surveys by the N.Y.U. unit in schools of the lower East Side of Manhattan reveal that at least one third of all children in the first grades there do not have the perceptual and neurological organization needed to learn to read. The finding that over 30 percent of this "normal" population requires additional help to avoid school failure and consequent emotional decompensation impels the conclusion that such school based programs should be expanded and well-financed publicly.

THE JUNIOR AND SENIOR HIGH SCHOOL YEARS

The Commission has identified rehabilitation as a tertiary form of prevention: effective rehabilitation prevents continued use of drugs. It is, therefore, unusual to find a treatment program whose techniques would be applicable to concepts of primary prevention, or the elimination of any pressing need to rely upon substance abuse for gratification or relief of anxiety. The Commission staff had occasion to visit the Alpha School at 60 Hinsdale Street in Brooklyn, New York, during the autumn of 1973. We found a program there of intervention during the high school years which was most impressive, and which we believe encompasses methods that could suitably be extended to other high school settings. As the description of Alpha School unfolds, the reader may be struck by the irony that youngsters first had to become drug abusers and delinquents before being offered help in what may be the finest remedial education facility in the state.

The Alpha School is located in a small brick building in the East New York section of Brooklyn. It is a combined residential therapeutic community and high school, partly financed with drug treatment funds, and partly financed with prevention funds. From July 1, 1972 to June 30, 1973, there were a total of 83 new admissions. Approximately half of these children ran away and were, reportedly, subsequently taken in hand by other agencies. The stable census at any one time is approximately 32. Alpha School's sole criterion for admission is the desire of a child to attend its school. After a child is admitted he (or she) attends classes only after completing a written request to do so. The motivation of the children is a significant factor in the success of the operation. While some might argue that agencies working with children should help them develop motivation, this Commission's finding, that manipulation of attitudes of children on the brink of trouble is impossible, would militate in support of the Alpha School criterion for admission. We view intervention in the early years, previously described, as the only way to avoid wasting the lives of the type of children who refuse to go to the Alpha School, or who run away and refuse to return.

The children at the Alpha School are usually evenly divided between boys and girls. Eleven of the new admissions were under 16, 29 were over 16 and 43 were just 16. Half were referred by the courts (mostly Family Court, some Criminal Court); nine were referred by schools; 3 were referred by other non-court agencies; and the remainder were referred by friends or relatives. Approximately three-quarters of the students had previous contact with other agencies prior to their admission.

Approximately two-thirds of the students had been using heroin for two or more years prior to their admission; only one of these was under 16. Five other students admitted marihuana or hashish use; 3 used pills or cocaine and one abused alcohol. Eighteen other students were either truants or outright delinquents.

The Alpha School staff is comprised of an Executive Director, a clinical staff and five schoolteachers. The teaching staff and the clinical staff appear to have respect for each other, and, under very firm, but sophisticated leadership of the Director, each group has an equal voice in determining policies that affect the direction of the school. Roles are frequently shared and exchanged: for example, teachers participate in encounters and clinicians help plan educational strategies.

According to the Executive Director, when the Alpha School first began, the staff decided to offer the children a variety of nebulous opportunities, such as "freedom" and "self-realization". They quickly discovered that they had created a school not for children, but for themselves, based upon their own fantasies of what they had lacked as students when they were young. They swiftly changed their approach to one more educationally result-oriented. While they are still not satisfied that they are meeting all of the complex needs of the children, they do believe that the needs they are meeting are those of the children and not of their own or of "the system".

One of the decisions they had to make was whether to focus primarily on helping the students fill sizable gaps in their education, due to truancy and dropping out, or to concentrate on the development of thinking skills, trusting the students to then fill in their own gaps with subjects additionally provided. They chose the latter course.

Their educational approach is "Education for Survival", and includes the basic skills necessary for functioning in most occupations and in everyday life. The following minimum levels of competence have been established:

English: A student must have reading ability of sufficient level to enable him to read a newspaper, fill out an application form, read a traffic sign, etc.

Mathematics: A student must have a firm grasp of the arithmetic necessary to handle money, bank accounts, credit, tools, etc.

Biology: A student must have a least a minimal understanding of his own body to be able to care for his physical well being.

Social Studies: A student must have an awareness of the social and political institutions with which he will interact, as well as an overview of the workings of society as a whole. He must have some understanding of his ethnic identity and of the forces of history which have given rise to existing conditions.

Once a student has achieved minimum competence in these areas, he may choose among the following options: preparation toward a high school equivalency diploma, vocational training, or return to public school.

Equivalency Diploma

One of the alternatives available to many students is high school equivalency examination preparation. Although students with the academic potential of passing this examination are not required to take it, most are encouraged and eager to do so. The overwhelming majority of students in Alpha School enter the program years behind in terms of high school credits earned. Most cannot complete the number of courses required for a regular high school diploma in a reasonable period of time and, therefore, most elect to obtain a high school diploma by examination.

A paradox of our education system is that although much of the information needed to pass the high school equivalency examination is not necessarily useful in certain jobs, the diploma is often a prerequisite for these jobs. Realistically, a high school graduate has many more alternatives open to him vocationally as well as academically, and, accordingly, a high school diploma can be viewed as a survival tool.

Although the importance of obtaining a high school diploma is stressed in many ways at Alpha School, they are also aware of several problems that accompany overemphasizing its value. Many students in their program cannot have the diploma as their goal due to their age or academic abilities. They are helped to realize that their goals are equally as valid as those of students in the equivalency program. Secondly, some students find it extremely difficult to handle the pressures of test taking and of intensive study required prior to taking the test. Therefore, all students have the right to decide whether they will prepare for the examination and are not forced to take the examination unless they feel that they are ready.

In summary, obtaining a high school equivalency diploma is considered part of Alpha School's survival curriculum only for those students who are old enough to take the examination, have the academic ability to pass it, and who have the desire to prepare for it. Obtaining the diploma is thus a priority which is of an order of magnitude lower than achieving minimum level of competence, which is the first priority of all students.

Vocational Training

Another alternative open to students who have achieved minimum levels of competence or who have been in the program for a while and do not plan to prepare for the high school equivalency examination is vocational training. Alpha School has very limited resources for training students in various vocations, and most students are referred to other agencies and schools. Alpha School does offer elective courses in typing, photography, and drafting during the school day and students get some limited experience as cooks, auto mechanics, carpenters, painters, and secretaries during their daily job functions. These experiences serve primarily to motivate students to further their abilities by training at outside institutions after graduating (and in some cases before graduating) from the program.

The survival curriculum has been designed to be sufficiently broad to include skills that are necessary in a wide variety of professions and sufficiently flexible to adapt to the needs of a student who has decided to concentrate on learning a specific trade.

Each student is counseled at regular intervals by a group consisting of a member of the educational staff, a member of the clinical staff, and the community liaison. At these meetings he is helped to plan for his future. The plan arrived at may involve further education, vocational training, or a combination. When a student has made tentative goals for his future, the role of the educational staff becomes that of a resource team, helping the student fill out application forms, providing the student with relevant material, directing the student to further information in his chosen field, and reenforcing survival skills the student will find necessary in that field.

Return to Public School

Students who graduate from Alpha School may elect to return to their home schools. In the past students who have chosen this option have been the exception rather than the rule. However, the survival curriculum must prepare students who choose to return to their home schools with the ability to compete with others in their grade.

Class Groupings

Students enter Alpha School with a wide variety of abilities, academic experiences, and grade levels. Most have severe gaps in their educational backgrounds; most were truant for extended periods before entering the program; most enter functioning at a level well below that expected of students their age. Due to the rather special nature of Alpha's student population and the special problems that arise in teaching students who were considered failures by their previous schools, the educational staff has decided to group classes according to the individual needs of the students, rather than according to the last grade they achieved in their former schools.

Each student is placed into one of five fairly homogeneous groups for his English, Social Studies, and Science clases. Since reading ability is the most important tool in these subject areas, the placement is made primarily by reading level. Often a student's reading and mathematical abilities show great discrepancy and, therefore, his assignment to one of five homogeneous mathematics classes is made independent of his reading group assignment. The decision to create five separate groups for reading and math was not made arbitrarily. Rather the curriculum seems to be composed of five discrete phases, with logical transitions from one phase to the next.

There are no levels for art classes since most students work semi-independently in this area. Art classes and electives (such as typing, photography, shop) are assigned as the student's schedule permits.

Below is a description of each of the groups followed by a chart summarizing the relationship of these groups to minimum level of competence.

Mathematics Groups

Basic Math: This group is designed to teach basic arithmetic (addition, subtraction, multiplication, and division) and basic mathematical concepts (telling time, learning how to use calendars, learning how to pronounce numbers, the structure of our number system, etc.)

Applied Math: This group concentrates on advanced arithmetic (fractions, decimals, percentages) and on survival skills related to these topics (measurements, bank accounts, consumer education, etc.)

Advanced Topics: This group is composed of students who have achieved the minimum level of competence in mathematics but have not yet begun preparation for the high school equivalency. Topics covered include algebraic equations, geometry, and physics. Moreover, the course lays the groundwork for future equivalency preparation.

Pre-Equivalency: This group is composed of students who need long term preparation before taking the high school equivalency examination. The course reviews concepts of advanced arithmetic and begins work on algebra and geometry.

Equivalency: This group is involved with immediate preparation for the equivalency test. The course involves intensive study in algebra and geometry as well as practice on sample tests.

Reading Groups

Basic Reading: This group is composed of students who are functionally illiterate (reading below fourth grade level). The course is designed to teach these students basic skills in phonics and reading.

Elementary Language Arts: Students in this group have mastered many basic reading skills but have low reading levels. Their goal in reading is to acquire increased fluency and comprehension.

Critical Reading: Students in this group are fairly fluent readers with minimal functional reading levels. The course concentrates on increasing students' depth of understanding of written materials, teaches them to be more accurate in their interpretations of their readings, and helps them to further refine their logical thought processes.

Pre-Equivalency: This group is composed of students who need long term preparation for the high school equivalency examination. The course reviews and advances the students' critical reading abilities and begins the formal study of literary terminology and grammar.

Equivalency: This group is involved in intensive study of areas tested by the high school equivalency examination.

All of the students meet together for their English, Science and Social Studies classes. The Basic Reading, Elementary Language Arts, and Critical Reading groups work on the survival curriculum in each subject area, with the Critical Reading group also studying more advanced topics.

In English, the reading goals mentioned above are supplemented by development of writing and language arts skills commensurate with the reading ability of the group. In Science and Social Studies these groups cover similar content, but are provided with reading materials appropriate to their reading levels. Whenever possible, the Science and Social Studies courses serve to reenforce the groups' reading goals while covering the survival content.

The Pre-Equivalency and Equivalency groups are composed of students who function well above the level of minimum competency. In English, Social Studies, and Science these groups study the content areas covered on the equivalency examination, practice on sample tests, and learn more advanced reading comprehension and test-taking techniques. The content covered by the two groups is virtually identical, and the courses differ only in pace. The areas of competence included in the high school equivalency examination are grammar, English usage, correctness of expression, literary interpretation, general reading comprehension, and specific reading comprehension of complex science and social studies materials.

The groups described above have been structured to allow students to advance with ease to the next most difficult group after mastering the skills of the previous group. In some instances a student may be advanced two groups. For example, he may be placed directly into the Equivalency group after doing well in Critical Reading.

Criteria for Placement

Starting School

Each student begins classes as soon as possible after entering the program. During his initial orientation period, the educational staff has informal personal contact with the student during various house activities. When the initial educational profile is completed, the student begins classes, in most cases at the start of the next five weeks cycle. Although on occasion students may be placed in classes mid-cycle, it is often confusing for the student to enter school behind the rest of his class.

Many students have been found to have serious perceptual, physical and emotional problems which require attention. Until recently, no medical services were available. Now, liaison has been established with a local hospital for medical work-ups. Nevertheless, the staff finds that students must be sent back several times to obtain necessary information regarding perception.

Initial Placement

A student is assigned to classes after his request to attend school has been approved by the clinical staff. His placement is based on three criteria.

1. Diagnostic Test Results. Shortly after entering the

program the student is given a series of diagnostic tests. From these tests a student's educational problems are diagnosed and grade levels in reading and math are obtained. The grade levels achieved and skills breakdowns obtained are the primary criteria used to assign the student to classes.

2. Personal Evaluation. During the first few weeks of the student's stay at Alpha School he has informal contact with the educational staff. The teachers' evaluation of each student's individual personal needs helps them to assign him to classes where he can receive the best possible attention from the teacher and the most helpful peer environment. In addition, meetings with clinical staff are invaluable in helping teachers form a more complete impression of potential students.

3. School Transcripts. At intake each student's parents sign a form requesting that the student's educational transcripts be sent to Alpha School from the student's former school. Since February, 1973, when Alpha School became affiliated with P.S. 203, official records are requested as well. As Alpha School is ungraded and most entering students show records of poor attendance for their past few semesters, these records have only limited usefulness in placing students. However, these transcripts and record cards do give some indication of the student's ability to function in a school atmosphere and his academic achievement. Particular attention is paid to the health records accompanying the student's official record card. Health and physical problems are carefully noted, particularly visual and perceptual problems

previously diagnosed, and help the educational staff determine whether referral to outside agencies for these problems will be necessary.

Subsequent Placement

At the conclusion of each five weeks cycle, each student's class assignments are reviewed and modified if necessary. Students who have progressed sufficiently advance to higher level groups. In some cases students who have difficulty competing in their assigned group are moved to a lower level group. This second alternative is rarely taken, however, due to the negative effect of a "demotion". In other cases, students who are near the borderline of two groups are placed in the higher group to challenge them to rise to a more difficult situation, while others are placed in the lower group when it is found that they are inhibited by overly competitive situations.

As the educational staff learns more about each student with time and has an opportunity to observe his performance in class, the student's placement becomes more accurate. However, Alpha School's initial diagnostic techniques have developed to the point where few adjustments are necessary.

In addition to regularly assigned classes, each student who demonstrates his ability to be responsible for his education is given the option of taking one or more elective courses. Students who have severe academic deficiencies or who are involved in high school equivalency preparation are encouraged to concentrate on their core curricula and usually do not have the time for electives.

Scheduling for Needs

Daily Schedules

The school day at Alpha School consists of six 45 minute periods beginning at 8:30 a.m. and continuing until lunchtime at 1:15 p.m. with a fifteen minute break between third and fourth periods. Students are provided with two hours of additional study time from 9 to 11 in the evening. During the hours of school and evening study students are excused from all other responsibilities and are free to concentrate their full attention on school work.

The daily schedule has been designed to afford maximum flexibility and individualization of programming. Classes are scheduled so that reading and math group placements can be made independently of each other. In some cases this requires that students who meet as a group for their English, Science, and Social Studies classes must be placed into three different Mathematics groups without program conflict. When the number of students assigned to a particular group becomes large or when many new students enter a group that has already covered much material, a new section for that group is created. This insures manageable class sizes necessary for individualized instruction and allows students to be absorbed into the school at various times of the year without the disadvantage of finding themselves far behind the rest of their group.

Some classes, such as Equivalency Math or Basic Reading, require daily sessions of a single period in duration. Other classes, such as Science courses in which laboratory work is emphasized, need more than a single period class to be most effective. Therefore, although all classes meet for a total of five periods a week, the day has been structured to allow for two different arrangements of time. The first three period classes meet for a single 45-minute period daily, while the last three periods are structured to allow each of these classes one double period session a week. Whenever possible classes are scheduled to meet in time arrangements more appropriate to class activities. (No double period classes are scheduled for Thursdays. This day is used when necessary for school trips, films, seminars, etc. without the loss of more than one period by any class.)

Each student is given a full six period schedule consisting of English, Mathematics, Science, Social Studies, Art, and Study or Elective. Students preparing for the high school equivalency may be excused from Art to gain more study time and students with severe reading deficiencies may attend two reading classes while losing Art. However, the overwhelming majority of students take the six classes described above.

Yearly Schedule

The academic year from September to June has been divided into eight segments or "cycles" lasting approximately five weeks each. Classes are recessed for two days at the end of each cycle to provide the educational staff time for overall school planning, preparation of materials, and evaluation of student progress, problems and class placement. No formal classes are held during Christmas and Easter weeks and on several legal holidays.

The eight cycle system has been found to have several marked advantages over the more usual quarter system. The cycle system provides a convenient structure for absorbing new students at regular intervals. New students are admitted to classes at the beginning of each cycle or, in exceptional cases, during the first week of the cycle. As students are given two weeks in which to orient themselves to their new surroundings before entering classes, the maximum delay a student can experience before starting school is six weeks. More typically, however, the delay is between two and four weeks.

Another advantage of the cycle system is that it lends itself readily to teaching curricula composed of more or less quantified units while, at the same time, it can be adapted to long term projects. For example, most teachers at Alpha School have planned curricula which can be divided into several units that can be covered in approximately one cycle each. This breakdown into units allows both student and teacher to focus on particular aspects of the survival curriculum during each 4 1/2 week period and begin the next cycle with a new topic. In this way new students are not placed at a disadvantage when entering classes, students can more readily perceive short-range academic goals, and both students and teachers can more accurately plan long-range goals. On the other hand courses which are more continuous in their subject matter can use several cycles or even a full year to cover their material. Thus teachers are not necessarily bound to 5 weeks time periods, but can allow exploration of particular subject matter to flow into the next time period.

At the conclusion of each cycle, each student receives a written evaluation from his teachers. Thus, under the cycle system, each student is evaluated eight times a year. The advantage to the student of more frequent evaluations should be clear, while the educational staff has increased opportunity to revise students' programs as the result of the academic performance they observe. In the very rare instance of a student whose behavior warrants his losing the privilege of attending classes, the student can be dropped for a single cycle and be reabsorbed at the end of a relatively short period of time. In more usual circumstances, students can reassess their own progress and attitudes toward school at frequent intervals and make the necessary adjustments. The two day break at the conclusion of each cycle provides students with a welcome rest period from their intensive studies and gives teachers time for planning and clerical work.

Evaluation

Independent evaluation of the Alpha School has been provided by the Institute for the Development of Education as a Growth Opportunity (IDEGO). The following are evaluations of the educational program, as of June 30, 1973. Results have been gauged by use of standardized achievement tests, teacher-prepared diagnostic tests, and the extent to which students were actually prepared for high school equivalency examinations or vocational training.

A the outset of the academic year the students were given achievement tests. On the basis of these results, the students were divided for research purposes into two groups: The progress of the nine students who were to be prepared for equivalency would be evaluated in terms of their results on the examination. The progress of the other twenty-three students would be evaluated by changes in their scores on achievement tests and teacher made-diagnostic tests.

1. Achievement Test Scores

This report includes the results of twenty-two students who were tested at the outset and then retested at the end of the academic year. The results of the testing and retesting of the three students who were first tested at midyear have been omitted.

A. Math

The average gain per student during the academic year was three years. This is three times the expected rate of progress for the average student in the average school. It is also three times the rate of progress achieved by Alpha School students during the previous year. Students whose scores at the beginning of the academic year were seventh grade level or higher gained an average of 3.4 years. Those whose scores were sixth grade level or lower gained an average of 2.5 years. This difference, that relatively better functioning students progress at a faster rate, is consistent with previous findings.

B. Reading Comprehension

Students who began the year with scores at the seventh or eighth grade level gained an average of at least two-and-a-half to three years during this period. A more exact figure cannot be reported because all but one of these students scored as high as the test permitted. Students whose initial scores were fifth or sixth grade level gained an average of 1.8 years during this period. And students who had scored at the fourth grade level or below gained an average of 1.5 years.

Once again, the results indicate that the higher functioning students progress at the fastest rate.

Standardized tests were consistently administered as tests of ability, untimed, for research purposes.

2. Teacher-Prepared Tests

All students were administered extensive diagnostic testing at the outset of the school year which indicated their exact strengths and weaknesses in the various academic areas. Based on these test results, the student population was divided into five groups according to their overall functioning and each student was given an individualized curriculum. At the end of the year students were retested. In general the results of the teacher-prepared diagnostic tests clearly indicate that significant progress was made by most students in the program. However, the kinds of progress did seem to vary with the level of functioning of the students.

A. Basic Reading Level Students

The few students in this group made significant progress in the four academic areas, especially after the teachers came to grips with their tremendous lack of basic knowledge in these areas.

However, as noted by all four teachers, these students did better on material described as "concrete" "details" "rate", and "computational" than on skills described as "conceptual", "non-computational", "involving more than one step", and "problemsolving".

B. Language Arts Level (Applied Math) Students

This group did extremely well in all four subject areas.

C. Critical Reading Level Students

This group made the least progress in those subjects involving reading: English, science, and social studies. The educational staff suggests that this group appeared to be the least motivated. The teachers felt they were not as educationally handicapped as the lower functioning students and did not share their felt need to learn how to read, write and do arithmetic. And since they were not ready to engage in an equivalency diploma or pre-equivalency preparation, they did not have the same incentive as the higher functioing groups. However, while part of the explanation for their relative lack of progress may be motivational, it is clear from the teachers' self-analysis and their evaluators' observations that a rethinking of the curriculum for this group is in order.

3. High School Equivalency Students

Nine students were enrolled in this curriculum at the outset of the academic year. By the end of June, eight of these students had earned their diplomas. The ninth student passed all of the subject areas subtests but did not achieve a high enough overall score to receive his diploma. He is scheduled to retake the examination in July.

4. Vocational Training

Eight students were referred and accepted for vocational training. Five are currently enrolled in vocational training. Two terminated to accept satisfactory jobs and one was terminated by the vocational training school.

OTHER ALTERNATIVE SCHOOLS

Typical of the conceptual problems in education, particularly in relation to misbehavior by students, is the extent to which the system should adapt to the student and the extent to which the student should adapt to the system. One of the reasons the Commission has been impressed by the efforts of the New York University Medical School's Learning Disorders Unit and of the Alpha School is that these programs envision the student as a client, for whom professional services should be at the same level as for a respected adult client who might visit a physician, attorney or family counselor. The Fleischmann Report indicated that our educational system frequently does not serve the child as client; rather, it tends to serve the interests of the system, itself. A phenomenon of modern helping organizations is that upon their first measure of success and subsequent enrichment and expansion, they often lose sight of the individual human being, whose interests and needs are the very reason for their existence. It would be unwise to suggest that the client be placed in a position to dictate against sound professional judgment. However, when the adaptation of the client is the end being sought, the means must never be far removed from the provision of services tailored to the needs of that client.

Alternative schools in New York City apparently mean both adaptation of the system to the individual and of the individual to the system, depending upon the context. One attempt to adapt to the needs of the students, without reference to drug abuse, but with a view toward deterring a variety of forms of misbehavior, including drug abuse, has been the establishment of mini-schools within Haaren High School in New York City. Other mini-school programs include the famous, once privately financed Harlem Prep, which is now being absorbed into the public school system; O'Henry Prep; Thomas Jefferson; DeWitt Clinton; James Monroe; and the Bed-Sty* Street Academy.

The Haaren mini-schools were developed under the aegis of the New York Urban Coalition. First National City Bank helped sponsor the planning and blue-printing of the set-up, which was accomplished in 1972. This involved transforming the 2,500 student, all-male, high school in the Hell's Kitchen section of Manhattan into twelve semi-autonomous education units averaging 150 to 200 students and six teachers each.

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*Bedford-Stuyvesant

AUTOMOTIVE

The AUTOMOTIVE mini-school is a two-year program starting in the tenth grade. Students receive an introductory course in shop, consisting of the use of tools and equipment necessary to repair and maintain the basic parts of the modern automobile. Academic courses covering the history, nomenclature and technical problems of the automobile are given to all tenth grade students. Students who successfully complete the tenth year may choose to continue in the eleventh year of the mini-school. The eleventh year consists of: the BUSINESS OF A SERVICE STATION. Students are trained in the mechanical duties, salesmanship and management of a modern service station. The service station training received in the eleventh year should permit a student to obtain a co-op job in a service station during his last year at HAAREN. A student will be allowed to enter the service station course in the eleventh year without taking the introductory tenth year course.

AVIATION

The AVIATION mini-school is a three-year course beginning with sophomores. The shop course begins with aviation woodworking and advances through metal work, basic aircraft powerplants and accessories, modern aircraft powerplants and components, pre-flight and aviation electronics (avionics).

A. Sophomore year: Regardless of his reading or mathematics level, the sophomore is admitted to the program if he shows that his interest is indeed aviation. He is given intensive instruction in English, Mathematics, Aviation, Woodworking, Metal Work, Mechanical Drawing, and Related Technical instruction.

B. Junior year: In his junior year the student is given instruction in basic aircraft powerplants and accessories, Mechanical Drawing, and related instruction in English, Mathematics, Science, and Related Technology.

C. Senior year: Seniors are given instruction in pre-flight and modern aircraft powerplants and components, and avionics, along with advanced subjects in other areas.

It is the intention to prepare students for further education in aviation oriented institutions of higher learning, and/or employment in the aviation industry.

CAREERS

The CAREERS mini-school is a mini-school which provides students with detailed exposure in the following six areas: 1) Communications, 2) Business, 3) Professions, 4) Health, 5) Transportation, 6) Civil Services. The careers class is designed to strengthen the student's interest and abilities, and along with a correlated approach in the areas of English, Social Studies, and Math helps the student make a successful selection for his future educational development.

The CAREERS mini-school is designed for tenth graders who have lost confidence in themselves or the educational system. Its thrust is to regain the student's confidence by orienting him to broad career areas with supportive educational development.

COLLEGE BOUND

The COLLEGE BOUND Program is a federally funded program with special allotments for educational assistants, tutors, a summer program, small remedial classes for reading and mathematics, and one counselor for every one hundred students. This program is available to entering ninth and tenth year students with academic potential and a reading level of two years retardation. Opportunities for cultural experiences, group programming, flexible curriculum, group counseling and extra help in language art skills and mathematics are other features of the program. Graduating College Bound students with an average of 70% or more are guaranteed a seat in one of the 117 participating colleges and universities, including CUNY and such schools as Harvard, Princeton and Columbia. In addition, all participating colleges may offer financial aid packages to the College Bound student. Elective courses are offered in the areas of English and Social Studies.

CO-OPERATIVE - BUSINESS

The CO-OPERATIVE - BUSINESS Work-Study Program is an alternate work program designed for the junior and senior years. Students are employed for one week training periods, alternated with one week of schooling for the two-year period.

This program is designed to prepare the student to:

1. Obtain employment in clerical and accounting sections of business.

2. Prepare for and obtain Civil Service jobs.

3. Develop necessary skills to function successfully on jobs.

    a. English Skills - Filling out varied forms, letters, resumes, business reports; clear oral expression; understand and follow oral and written directives.

    b. Lab - Use of office equipment (typewriter, calculator, mimeograph, etc.).

    c. Simulated office practice (bookkeeping, inventory, processing credit, etc.).

    d. Improvement in arithmetic skills related to business, e.g., computation.

4. Attitudes toward business (ethics, values) that affect interpersonal relationships on the job (punctuality, attendance, enthusiasm, etc.).

5. Upward Mobility

    a. Preparation for those students who plan to attend college for highly skilled jobs.

    b. Knowledge and training for those students interested in small business ownership.

ENGLISH AS A SECOND LANGUAGE

The ENGLISH AS A SECOND LANGUAGE mini-school provides intensive language learning to the foreign student and aids each student in his adaptation to American society. Instruction is offered to beginning, intermediate and advanced language learners with courses in English, Mathematics, Science, Social Studies, Reading, Career Guidance and Language Laboratory. The curriculum emphasizes an interdisciplinary approach of audio-lingual methods, and a variety of media-oriented activities. New York City's cultural, recreational and service facilities are used to familiarize the student with his new environment. Students graduate from the mini-school upon achieving a competency in English which is self-sustaining to the student's individual goals -- be he job or college oriented. The school's staff aims for total participation in the mini-school community. Currently, students come from 21 nations of the world.

HAAREN PREP

HAAREN PREP is designed to allow each entering ninth year student to assess his own abilities and interests and to choose the appropriate tenth year mini-school. Through the use of video equipment, reading machines, special materials, and individual consultations, the student is guided to the understanding of his need for improvement of reading and mathematics skills, to work harmoniously in groups, and to explore vocational options.

HIGH SCHOOL EQUIVALENCY

The HIGH SCHOOL EQUIVALENCY mini-school offers a program designed to prepare students of 17 years of age and over to pass the High School Equivalency Examination. The course of study consists of the five subject areas that appear on the examination: Social Studies, Science, Mathematics, Literature, and Grammar.

Special attention is paid to the individual needs of students: their strengths and weaknesses are taken into consideration and emphasis is placed on improving their skills in reading and arithmetic.

In their class work they use practice materials similar in content to those which students will meet on the actual High School Equivalency Examination.

Upon passing the High School Equivalency Examination, students will be awarded a Haaren High School diploma in addition to the High School Equivalency diploma awarded by the New York State Education Department.

For those students who are reading below a 5.0 grade level, they offer a program intended to bring their reading grade up to a level that will enable students to prepare successfully to pass the High School Equivalency Examination.

PRE-TECHNICAL

The PRE-TECHNICAL mini-school offers a three year course of study designed specifically for students who have an interest in a technical career.

At the completion of their studies in the Pre-Technical mini-school, the graduating seniors will be qualified to enter a community college on a technical level, or be qualified for a position as entering level tradesmen.

In order to understand fully the design of the Pre-Technical mini-school, it will be helpful to look at the sophomore, junior and senior years separately:

A. Sophomore year: The entering sophomore is admitted to the program on his interest only regardless of his mathematics and reading level. He is given a program consisting of an intensive remediation in English and Mathematics, an Electrical Shop, Mechanical Drawing and Related Technical instruction. The use of video equipment in all classes adds both motivation and pre-vocational training.

B. Junior year: Here the program divides into a vocational and technical-college bound track. All records of eleventh year students are reviewed, interviews are conducted and the students are placed in either the vocational or college bound track.

The technical-college bound student takes regular college preparatory courses in Mathematics, English, Physics and Chemistry, plus special technical shop course in plastics, metalworking and woodworking.

The vocational student specializes in small appliance repair plus correlated courses in English, Mathematics and Science.

C. Senior year: In the senior year both tracks are continued with the vocational student specializing in major appliance repair and the college bound student specializing in electronics.

SENIOR

The SENIOR mini-school is designed to accept and support those students who are not prepared to make career commitments; or who have not indicated or demonstrated career choices specific enough for enrollment in other mini-schools. It also accepts and supports students who have not fully committed themselves to college, or who have been dropped from the "COLLEGE BOUND" Program.

This support takes the form of a general education preparing the student for admission into an entry level job or into college. In this context the SENIOR mini-school offers a variety of courses including Photography, Ceramics, Major Art, and Chess.

SPECIAL EDUCATION

On the whole, our country is a highly industrial nation. The SPECIAL EDUCATION mini-school is designed to serve as a bridge between schooling and the every day world of work.

As a member of this mini-school, the student is brought face-to-face with the many aspects of choosing, getting, and holding a job. As a means of helping the student to meet these goals, several out-of-school programs have been set up. A student will actually do volunteer work in a Government hospital and have a short, paid, sojourn (two weeks) in a factory.

As a correlation of attaining these goals, the student should have increased his reading and arithmetic skills as well as his understanding of his role in the society in which he lives.

Unlike the Alpha School, which stresses intellectual accomplishment, the approach at Haaren is aimed at stimulating student interest, especially through a profound respect for the student's emotional life, as exemplified with this poem by a boy in a similar mini-school environment at DeWitt Clinton High School:

Nevertheless I love you

I'd give up on me if I were you
I wouldn't accept apologies
after the event
I'd say you've done it again
I'd say won't you ever learn
I'd say, well that's it
you're out
If I were you
I wouldn't love me like you do
father.

At the time the Commission staff visited Haaren, a delegation of educators from the Southeast Bronx was also in attendance to determine whether the mini-school plan should be adopted in their districts. They were most impressed with the sixteen "street-workers" who function at Haaren as counselors to the students.

Fifteen counselors function throughout the mini-schools, with one supervisor, a social worker who is planning to enter the teaching profession. One other counselor is a rehabilitated addict and several others have experimented with drugs in the past. These street-workers do not function as official guidance counselors, nor are they officially connected with the SPARK drug abuse prevention program. Rather, they function to keep order, to serve as confidants to the students and as role models for the students. Although their ultimate recourse is the educational system, and there is no formal guarantee of confidentiality between street-workers and students, their relationship with students appears to be friendly and useful, and students do not appear to resent or avoid them.

On three levels, the mini-school approach exemplified by Haaren raises serious questions. According to the staff at Haaren, the most serious problems affecting their students are family problems and family disruptions. The conduct students observe of their parents and the conduct the school asks of the students are in moral terms often so distant from each other, that the students simply cannot reconcile the two. While hard drug use is not a resultant problem at Haaren, heavy use of marihuana is known, and abuse of alcohol by students has increased significantly within the past year. Moreover, at least one report by school authorities of unlawful sale of alcohol to Haaren students has allegedly not been acted upon by the police.

The absence of school or community personnel whose function it might be to help reconcile Haaren students and their parents represents one of the gravest omissions of the non-therapeutic mini-schools.

A second level of concern involves the absence at Haaren of any meaningful medical evaluation of students. When the Haaren mini-schools were first established, representatives of the New York Urban Coalition went to the New York City Health Services Administration to request that a learning and medical diagnostic unit be established at Haaren. They pointed out that unless corrected, poor nutrition, failure to detect perceptual difficulties, and untreated physical and emotional symptoms would militate against the success of the experiment. The Health Services Administration rejected the proposal, alleging the incompetence of the Urban Coalition to take such a position. The Urban Coalition then went to administrators of Roosevelt Hospital, which is across the street from the school. Reportedly, Roosevelt Hospital has taken the position that it will treat students with Medicaid cards who have specific complaints, but it will not join with Haaren officials in establishing a regular referral service for students whose learning problems may be attributable to health care deficiencies.*

Haaren teachers report that the school medical records of students are haphazardly kept, poorly organized and not followed-up. They strongly suspect the presence of serious health deficiencies, but do not have the means to diagnose or remedy such problems.

A third level of concern at Haaren relates to whether students are actually overcoming learning gaps, or whether increased attention, stimulation of interest, and the novelty of the system have operated to make students more docile, but equally ignorant.

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*Conversation with Louis B. McCagg, Program Director, New York Urban Coalition.

Circumstantial evidence that this may be the objective of some of the non-therapeutic mini-schools was apprehended in the decision to evaluate Haaren's mini-schools in terms of an attitudinal survey, rather than in terms of scholastic achievements. The survey was performed by Fox, Fox and Associates, an evaluation firm certified by the State Education Department. There is no doubt that the attitudes surveyed were correctly reported; rather, the doubt arises as to whether knowledge of these attitudes uncovered is seriously germane to the issue of quality education. Most peculiar, perhaps, was the reliance on student attitudes relating to student achievement in the published results.

METHODS OF EVALUATION

There were three: a questionnaire for all faculty and staff (teachers had to work through an extremely long 29-page one), a questionnaire for students and an interview guide that was used with the administrative staff.

RESPONDENT POPULATION

Categories: administrative, teachers, coordinators, guidance staff and students.

RESPONSE PERCENTAGES

Administrators: 84% (10 of 12); teachers: 67% (74 of 110); coordinators: 62% (8 of 13); guidance staff: 33% (6 of 18) and students: 60% (590 of *988).

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*Response % - only half the students on register were in attendance on the days the questionnaires were handed out.

POSITIVE HIGHLIGHTS

Teachers: The range of improvement in specific areas hit a low of 13% when teachers were asked whether staff attendance had improved, to a high of 69% when they were asked if they saw improvement in the quality of student/faculty interactions. The three aspects consistently considered improved (60% or more) were support for teaching activities in a psychological social sense, staff awareness of student needs and the quality of student/faculty interactions.

Administrators, coordinators and guidance staff: As a group, they all saw improvement more consistently than teachers.

Students: Positive appraisal of the students ranged from 39% to 65%, with the highest percentages listed for improved student behavior in class (60%), overall student behavior (55%) and staff awareness of student needs (65%); with overall student achievement (45%), student interest in learning (42%) and student attendance (46%), following.

NEGATIVE HIGHLIGHTS

Teachers: The highest percentages were listed for the deterioration in staff morale, in communication among the faculty, in the quality of faculty/assistant principal interaction and the quality of faculty/faculty interaction (28%) and for overall student behavior (24%) and for student behavior in class (22%).

Administrators, coordinators and guidance staff: The last two categories seldom saw deterioration. Administrators did; slightly more frequently. And in the same basic areas as teachers did.

Students: They did not report much deterioration. When they saw it, it was in the areas of lack of student interest in after-school activities (28%), in the world outside of school (21%), in learning (16%) and overall achievement (12%).

SUMMARY OF IMPRESSIONS

Teachers: They are still ambivalent in their feelings about Haaren's mini-schools. Successes and failures are daily occurrences. They do feel and identify with their particular mini-school, but because of this, they feel somewhat alienated from their colleagues. They do feel medical and psychological services for students should be improved. They do feel the need for greater autonomy of the mini-school (fiscal and curricular policy responsibility). They do feel a great distance between themselves and the principal and felt he was not exerting the kind of leadership they felt was needed. "In short, teachers noted improvement in some areas of student functioning, but on the whole, the nature and number of remaining urgent problems preclude them from rating the mini-school experiment as more than slightly successful."

Administrative staff: They are concerned about students. They acknowledged as positive the street-workers presence in the school. However, autonomy is a problem with them. Generally, they want to see more of it. Some feel this could be brought about by physically separate facilities for each mini-school; curriculum development, teacher training and discipline become individual mini-school responsibilities. Along these lines, the major problems perceived have to do with "the nature of the relationship between the principal and the rest of the school. Specifically, bureaucratic red-tape; nonavailability of the principal and a lack of leadership."

Students: From 55% to 65% of the students felt that the situation at Haaren had improved "with a majority saying that the school has improved since September of 1972 and of those in school for more than two years, an even larger majority said it has improved since before the mini-school reorganization". A majority reported changes in their behavior; expressing that they are now thinking about finishing school and about their future afterwards. Nearly half of those questioned (only half of the students on register were in school on the days the questionnaires were collected) reported an improvement in coming to school and going to classes. What they want most is a better staff, a new building, better facilities (laboratories, gym, classrooms) and a coed student population.

ON THE SUCCESS OF HAAREN

"The three respondent groups, considered overall, represent three different levels of general sentiment. Students are most consistently positive; consistently providing majorities on the dynamics studied. Teachers saw progress and in some areas such as relationships and improvement in student behavior: the positive majorities approach those provided by students. But generally, the teachers reported limited progress and a minority saw little change or even deterioration. Administrative and guidance staff, as a group, were more often split into a bimodal distribution of positive and negative views."

Alternative schools have also been used as a disciplinary concept. When it was found that the SPARK education programs were not deterring drug abuse, alcohol abuse or other behavioral problems, the drug abuse prevention personnel quickly became an extension of the disciplinary system. Their function was translated into one of providing counseling, alternative activities, but also to help segregate drug experimenters by referring them to alternative schools. The Addiction Services Agency Assistant Commissioner for Education and Training described the approach in this way: "What we are doing is confronting the student with the reality that the school system is not going to adapt to his needs, but rather he must adapt to the school as it is."*

Drug experimenters were removed from selected district junior high schools, and placed in alternative settings, with parental consent, with the prospect of returning them to their schools after 12 to 14 weeks. The alternative setting stressed encounter groups relating to behavior and attitudes and hoped for improved behavior and academic performance. Approximately 1,500 of the 900,000 New York City school children have been involved in this program. In February of 1973, the Health Services Administration reported a fair amount of success in improving the behavior of a number of these students. This Commission believes that such a program constitutes a secondary form of prevention (after suspected drug use) and even at that is a highly superficial approach. Our value judgment is that serious drug or alcohol involvement follows isolation of the student, either because of school failure, family problems or health deficiencies. Consequently, we have serious reservations about techniques which may serve to isolate students further from their peers or from the educational system. We believe that people tend to avoid drugs because they do not need to take drugs, not because they have been intimidated about them. We believe that intimidation will at best lead to a mere alteration in symptomatology, and at worst, confirm the low-esteem the student has of himself and cause his behavior to become more rigid and covert.

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*Health Services Administration Press Release, February 25, 1973.

COUNSELORS AND CONFIDENTIALITY

The discussion of the effectiveness of 16 street-workers at Haaren raises the basic issue of the role of counselors in the educational system. Clearly the street-workers are not the professionals who comprise the 4,000 members of the New York State Personnel and Guidance Association. This professional organization represents guidance personnel who work in schools, drug centers, rehabilitation institutions, employment agencies and other public and private institutions. To be certified by the State Education Department as a public school Counselor, a person must have a bachelor's degree plus 60 graduate hours in testing, psychology, counseling and other related sciences.

The function of the public school guidance counselor is usually circumscribed within the limits of helping students clarify career choices. In New York City, the typical guidance counselor works with as many as 1,000 students. Realistically, adjustment therapy or even referral for well-understood personal problems is not a function for which most school guidance counselors have sufficient time, particularly in light of the administrative and clerical functions they are asked to perform.

On the other hand, personal intervention by individuals who are not fully trained in dealing with the psychological and adjustment problems of children may not be beneficial.

This Commission believes that while no fixed number of students can be established by law as a suitable caseload for all guidance personnel, the ratio of one trained guidance counselor to each 150 students should be the goal of our education system.

Into the debate over the issue of the availability of counselors to help students cope with learning as well as other problems, has come the issue of the confidentiality of communications made to counselors by students who are concerned with drug experimentation, sexual experiences, social inadequacies or any of the vast range of problems about which youngsters may wish to seek advice. The Personnel and Guidance Association insists that unless the communications between children and counselors are rendered legally protected from disclosure to school authorities, parents, social agencies and law enforcement officials, students will not confide their problems to counselors and will thus be precluded from receiving help.

The Commission has made diligent effort to ascertain even any single instance of the refusal of a student to seek help because of a fear of disclosure. While such instances may, in fact, exist, the professional counselors continue to insist that the logic of their claim is more pertinent than establishing their need for such protection on a case by case basis. The Commission cannot be unmindful, therefore, of the charge that confidentiality is not being sought primarily for the protection of students, but to enhance the professional status of the counselors.

Confidentiality does not appear to be a concern of the non-professional street-workers at Haaren. Their easygoing relationships with students are based upon the much higher ratio of informal counselors to students in that setting. Moreover, the street-workers are not burdened by the same clerical and administrative duties as the professional guidance counselors. We believe that if the confidence of students is desirable, then the availability of professional guidance counselors, who have sufficient time to deal with the personal concerns of students, as well as their career objectives, would serve to build precisely such confidence.

The Executive Director of the New York State Personnel and Guidance Association testified before our Commission in Albany that either confidentiality should be protected by law or that a clearly defined statement of policy relating to student-counselor communications should be issued by each school board. Later, in Buffalo, the

Legislative Chairman of the Western New York Personnel and Guidance Association made a similar request. However, he cited three exceptions to the concept of confidentiality, which we believe completely undermine the Association's position.

These exceptions to confidentiality, admitted in both written and oral testimony, were that confidentiality should not be protected:

1. When the counselor "discovers that the client is unable or unwilling to assume responsibility for his own welfare." If he chooses not to report drug users, either to parent, school nurse or school authorities, how will the counselor cope with any resultant deleterious effects of drug use?

2. "When the counselor discovers that the client is unable or unwilling to assume responsibility for the welfare of others." If he chooses not to report drug users, how will the counselor cope with the student passing drugs to others?

3. "When the counselor's own attitudes about drugs diminish the effectiveness of the counseling relationship. For example, when the counselor...assumes a parental role."

This Commission believes that a professional relationship between counselor and child should be meaningful, and that reducing the number of students to be guided by any one counselor will help to achieve this end. We believe that good judgment should be one of the characteristics of a public school counselor, and that a segment of that good judgment relates to if, when, and how information received from a student is disclosed to others legitimately interested in his welfare.

One of the deepest concerns of this Commission is the desire of some counselors, who have little enough time now to process job and college applications, to replace parents of certain selected students who have problems, or, where the counselor-to-student ratio is high, to replace the allegedly neglectful parents of large numbers of students. We believe that for some students, the availability of the kind of role models provided by Haaren's street-workers may be of benefit. But to suggest, as some counselors have done, that parents who may be inattentive to certain needs of their children are incompetent to deal with their own children is to state a position from which even Dr. Spock has recently retreated.

When a child is troubled, a counselor should take advantage of every potential resource, whether in the home, the voluntary agencies of the community or in the school. The appropriate role of the counselor is to reconcile, where possible, to bring together, the child and those with a legitimate concern for his welfare. We believe that even when the issue involves drug use, one of the counselor's most important functions is to help parents learn to accept their children and help children learn to use their own parents as a resource, when they become troubled.

ADULT EDUCATION

As previously indicated under the subheading relating to the etiology of drug abuse, the conduct of adults who use mood-altering substances has a direct bearing upon the conduct of their children. Although adults may use alcohol in an accepted, if not entirely acceptable, fashion: or they may use stimulants and depressants dispensed pursuant to prescriptions which they have little difficulty in obtaining; expert testimony before our Commission leads us to conclude that children are far more interested in the effects of chemical substances than they are in the ethics of obtaining such substances. The fact that a mother uses Valium or Seconal with a prescription is not as important to her marihuana-smoking youngster as the fact that she has a substance available to ease her tensions.* Many witnesses have testified that adult education about the various drugs upon which we, as a society, have become perhaps too dependent, may be more important than education of youngsters, since the effect of the conduct of adults upon children is greater than the effect of drug education upon children.

The argument could be offered that if education, per se, cannot dissuade children, whose habits have been but recently established, how can education serve to dissuade adults, who may have been engaging in substance abuse for years? Moreover, even if such dissuasion were possible, how are adults to be persuaded in the first instance to take advantage of such programs?

Two specific concepts of adult education in relation to substance abuse might be worth exploring in this context. These involve the two most abused substances in America, alcohol and tobacco.

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*Robert L. Goldstein, Director, Psychiatric Clinic, Criminal Court of the City of New York; Pierre Thyvaert, Assistant Field Director, Boy Scouts of America; see also, Fejer and Smart, study cited, supra, Chapter II.

Recently, a School Nurse-Teacher in the Glen Cove Public Schools conducted a Smokers Withdrawal Workshop for mothers during school hours, with baby sitting services provided by the PTA for the preschoolers brought by the mothers. The program was so attractive and successful that a number of fathers expressed an interest in a similar program for afterwork hours. The result was that an evening program was begun, and both parents of a number of schoolchildren were able to end or to curtail their habits. While this approach might not automatically work to help parents who abuse stimulants and depressants, a consumer education program might be worth a try, featuring substances of common abuse but also including problems of finance and credit and landlord and tenant, as well as dangers of aerosols, food additives, generic drugs, and, finally, the non-therapeutic use of stimulants and depressants. As in the education of students, adults who learn to develop greater consumer acumen may be more circumspect in their use of products which may not be good for their families. In the event that substance abuse persists, however, they will at least have been helped to be more knowledgeable consumers.*

With regard to alcohol, the subject is far more difficult to broach to adults who so often believe that they simply could not be the very ones who contribute to the problem. It is our finding that most people have no compunctions about vigorous law enforcement in the area of the operation of a motor vehicle while intoxicated. We also believe that the arrest of drunken drivers should always result in severe consequences. We are favorably impressed by the results of an adult education program conducted in Dade County, Florida, which is offered as an alternative to imprisonment for the crime of driving under the influence of alcohol. We believe this program works because the people who take the course can no longer claim that alcohol abuse is someone else's problem.

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*Additional comments anent adult education reflecting the health of students will be found throughout the next section, which deals with school health programs.

DADE COUNTY'S DRIVING UNDER THE INFLUENCE OF ALCOHOL COUNTERMEASURES PROGRAM

DUI Countermeasures of Dade County, Inc. is a non-profit corporation which is affiliated with the Dade County Court and the Dade County Public Schools. The corporation conducts a mandatory program for persons convicted of driving under the influence of intoxicating beverages and for others interested in taking advantage of the curriculum. The purpose of the program is to give those enrolled enough information about the drinking driver problem to modify their future drinking and driving behavior and to help develop self-understanding so that the ones who have a drinking problem will be able to recognize it and take appropriate steps to change it.

The by-laws of the corporation state that the Board of Directors is to manage and control the affairs of the corporation. The Board is composed of a minimum of eight directors who are elected for a term of one year by a plurality of votes cast at the annual meeting of the Board of Directors. Directors receive no salary or compensation.

The by-laws indicate that the Board of Directors shall elect a president, vice-president and secretary-treasurer who will be responsible for the active management of the business and affairs of the corporation. The term of office is one year and these officers receive no salary or compensation.

The corporation conducts a program which is based upon the original Phoenix, Arizona, DWI Counterattack Course, with appropriate modifications for driving and drinking conditions in Florida.

The course consists of four sessions of three hours' duration and a counseling session with an alcohol services agency counselor. Fees for each student are $50 per course. The average class size is 20 students.

Program staff are selected by a personnel committee and all appointments are subject to the approval of the Dade County Court representative and the DUI Countermeasures board. The staff is composed of persons actively engaged in alcohol counseling agencies or other related social agencies, persons with knowledge in alcohol education and behavioral scientists who have group therapy experience. Educational requirements include a master's degree in a related field of alcohol and work and exposure in counseling, preferably alcohol counseling. Work experience can be substituted for educational experience upon the recommendation of the personnel board.

The Bureau of Driver License of the Florida Highway Patrol has recently released statistics for a one year period which indicate that, in a sample population of 10,000 students who completed the DUI course, the recidivism rate was 3%, compared with a 20% rate for a similar population who were not exposed to the course. Dade County statistics, gathered over a six months' period, show only two cases of recidivism in a 770 case study.

For the period September 1, 1973 to August 31, 1974, it is expected that the expenditures of DUI Countermeasures, Inc. will be met by the student registration fee. The budget is estimated as follows: **SEE CHART ON FOLLOWING PAGE:**

INCOME:

2500 students assigned at $50 registration each	$125,000
125 students unable to pay registration (5%)	(6,250)
Adjusted income	$118,750

EXPENDITURES:

Teaching staff (125 classes, including special sections)			
Instructors	25,000		
Assistants	12,500		
Total		37,500	
Counseling services			
Head counselor	11,500		
Counselor	9,500		
Spanish counselor (part-time)	3,000		
Total		24,000	
Administrative services			
Executive director	16,000		
Secretary	7,000		
Clerk-typist	6,000		
Total		29,000	
Employee benefits			
Group Insurance	1,600		
Professional Insurance (liability)	600		
Workmen's compensation	350		
Social Security	4,525		
Total		7,075	
Films and supplies		4,500	
Research		1,000	
Lindsey Hopkins Educational Center (2375 paid students at $5)		11,625	
Travel expenses		2,000	
Miscellaneous		2,050	
Total expenditures		$118,750	
			$118,750

Course Outline

The requirements for satisfactory completion of the course are 1) attendance at all four sessions or at make-up sessions in cases of unavoidable absence, 2) completion of all in-class and homework assignments and 3) payment of the registration fee, unless otherwise stipulated by the court.

The first session is partially comprised of registration and introductory remarks. One part of the registration card guarantees that data included thereon will remain confidential except for reports to the judge or for research purposes.

Each session of the DUI Countermeasures program utilizes one or more of the following educational techniques: 1) instructional activities, 2) films (with time allotted for introductory remarks and class discussion), 3) posters, 4) taped interviews, 5) in-class and homework assignments, 6) class discussions, 7) questionnaires and 8) guest speakers who represent sources of assistance. In addition, class members utilize free time and break periods to get better acquainted with each other and with the instructor and his assistant.

The basic purpose of the DUI Countermeasures program is to modify the behavior of the participants in relation to the drinking driver problem. Initially, the course seeks to point out the gravity and seriousness of the problem by utilizing films and posters which illustrate the relationship between alcohol consumption and auto fatalities and injuries.

The second step is to show how drinking affects individual functioning and impairs driving skill. Films and posters demonstrate the increase in blood alcohol levels and the delay in reaction times resulting from the imbibing of specific quantities of certain alcoholic beverages. Other effects discussed include poor judgment, impaired vision, confused and hostile responses and impairment of reflexes, frequently resulting in overcompensatory maneuvers and accidents.

The third step seeks to define problem drinking and, based upon student responses to a questionnaire, to help each student to determine how much control he has over his own drinking. With the aid of posters, the instructor demonstrates the symptoms of an alcohol problem including marital and other family problems, decline of income, alcohol-related arrests, loss of memory and loss of jobs. The instructor also demonstrates how students can avoid future cases of driving while the ability to do so is impaired by drinking. Suggested methods include drinking less, arranging alternative means of transportation or, for some, not drinking at all.

The fourth step focuses on the formulation of the student's own plan to avoid future cases of driving under the influence of alcohol. The instructor assists the students by reviewing the materials presented in relation to the drinking driver problem, the effects of alcohol on driving ability, the circumstances leading to DUI arrests, and the actual number of people in the class who have a present or potential problem with drinking.

The instructor discusses the individual's responsibility to control driving after drinking and to get help for a drinking problem, when necessary. Taped interviews, posters and a film document the sources of assistance to which a student with a drinking problem can turn. Guest speakers representing sources of assistance are also present to provide information about their approaches to the problem drinker.

Additional information is available from:

Hon. Frederick N. Barad
County Judge
County Court, Dade County
1351 N.W. 12th Street
Miami, Florida 33125

In a larger sense, of course, adult education should also include techniques for understanding and helping children. The concept of care for children which stretches from the pre-natal era to late adolescence is often regarded as idealistic. However, if adult education were to include courses for potential parents, as well for actual parents, the life of the as yet unborn children of tomorrow might be beneficially influenced. In the past, focus on child care has been limited to techniques of coping with children. We believe that adult education should focus on the location and availability of public and private agencies in the community which can be of continuing assistance to parents and to putative parents. Instead of merely listing such agencies, parents should be instructed in the scope of activities of such agencies and the means of qualifying for their services. In the event that existing agencies may be inadequate, then adult education groups could form the nuclei of community action groups to upgrade needed services. We make this proposal as part of our basic thesis that helping children and their parents on an individualized basis is likely to contribute more significantly to the prevention of drug abuse and other unfavorable childhood developments than belaboring the subject of drugs as if prevention could be accomplished solely by incantation and good will.

SCHOOL HEALTH PROGRAMS

A further irony of unmet student needs in New York state was illustrated by an official of the state Department of Health. Originally, he said, we outlawed child labor and mandated education, at least in part, to benefit children. Today, many employers provide not only reasonable wages and working conditions, but also more individualized counseling and medical care than is available to children in the educational system. As we shall demonstrate, the assumption that because children have parents who have a primary responsibility to care for them the schools need do little, is at best highly questionable.

We believe that the self-esteem of the child is the result of several factors: First, he must have respect for his mind, both in terms of its capacity for intellectual operations and in terms of its capacity to deal with emotional problems. Second, he must have respect for his body. Good health care for children is not only important as an end in and of itself, and as a means to enhance learning potential; good health care for children has a multiplier effect with regard to the child's respect for his own well-being. If a child with few health problems of his own observes the concern of society for the health problems of other children he learns that the body's continued integrity from disease or debilitation is a value to be prized. Third, a child must have respect for his own capacity to achieve valid goals, in terms of what society expects from him and in terms of what he expects from society.

The school represents, among other things, a forum for the development of the student's sense of self-esteem. We find that nothing in the educational system of our state is as important in this context as the school health program, and, unfortunately, nothing is so neglected. For example, on February 6, 1974,* the Health Commissioner of the City of New York admitted that school health programs were in a state of chaos. Attempts to persuade parents to take their children to the City's 77 child-health centers, in lieu of providing school screenings, had not been successful. Physicians were unwilling to work in the schools, and over a ten year period, the number of full-time school nurses had been cut from 900 to 222. As a consequence of this situation, the New York City Health Commissioner authorized a "pilot" program of screening, to begin in "one or two" schools.

This Commission find that there are three aspects of sound health care which should be implemented within the school system, without impinging upon the legal distinction between screening for problems which interfere with learning, and actual treatment, which the state does not deem to be the province of the schools, except in limited cases, such as the experiment conducted at P.S. 116 by the N.Y.U. Medical School's Learning Disorders Unit, described above. These three aspects of good health are: First, the use of diagnostic teams to screen for and remediate learning impediments, as at P.S. 116. Second, the use of far more trained counselors to help individuals among the general population of students not only with career planning, but also with personal and academic problems. Third, the use of far more trained nurse-teachers and non-professional assistants to act as primary health educators, to monitor the physical well-being of students, and to act as liaison between the school and the home with regard to specific health deficiencies of students.

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*The New York Times

Under New York state law, periodic medical and dental examinations are required throughout the state upon first entry into school and upon first entry into first, third, seventh and tenth grades. These requirements do not pertain to New York City, Buffalo and Rochester, which have their own parallel requirements. In the event that a parent does not provide the school with evidence of a physical examination of the child at these stages, the school nurses are supposed to report that fact to the school physician, who is then authorized to examine the child. With widespread gaps in the availability of school nurse-teachers and school physicians, these medical examinations are often omitted by the schools when they are omitted by parents. Of greater concern, the shortages of school health personnel have led to the omission of even cursory vision and hearing examinations, especially among large segments of inner-city children.* The unavailability of school nurse-teachers and assistants is a critical defect in the educational system. As in the case of counselors, we cannot recommend an absolute nurse to student ratio; however, based upon testimony of concerned health professionals, we believe that few school nurse-teachers, with an assistant for each, should be required to follow more than 300 students at any one time.

THE SCHOOL NURSE-TEACHER

The school nurse-teacher occupies a unique position in the school system. She is usually the only health professional in the school. In contrast to the classroom teacher, the school nurse-teacher can be in contact with a pupil and his family for a number of years. This continuous contact can help her to develop a greater rapport with her clients and to provide them with ongoing counseling and referral services.

The school nurse-teacher is in a non-punitive position in the school structure. She does not grade or discipline pupils. She can be available to all pupils, parents and staff and is equipped to provide them with assistance, counseling and referrals.

In addition to being a New York State certified teacher, the school nurse-teacher is also a licensed registered nurse. Her background includes courses in health education and health counseling. Permanent certification as a school nurse-teacher requires preparation at the master's level.

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*Testimony of Onslow Gordon, M.D., Chief Medical Inspector of Schools, State Education Department, Albany Hearing.

The school nurse-teacher has a number of responsibilities. As a health educator, she is responsible for pupil instruction, staff education and parent and community education.

The school nurse-teacher's responsibilities for pupil instruction include assistance to the classroom teacher in the preparation of a health instruction curriculum, including a drug instruction program (which we believe should be modified along lines previously discussed) actual teaching of other critical or controversial health issues, and assistance in coordinating the health instruction curriculum with the school's health service activities (e.g., vision and hearing tests).

Staff education conducted by the school nurse-teacher is necessary because the pre-service preparation of teachers does not adequately prepare them for their health related responsibilities and because there are continual advances in medical science and new developments in health education and resources. Such staff education includes instructions on the care and treatment of emergency illnesses and injuries, instructions on health observation and supervision of pupils and information concerning special health problems of pupils.

Parent education is designed to help parents develop sound and more effective methods of child care. When time is available, school nurse-teachers may also counsel parents with regard to their health needs, and may instruct civic, professional and social organizations on contemporary health problems. The school nurse-teacher also acts as a health consultant by advising school and community groups about the health problems and needs of the school community.

As a health professional, the school nurse-teacher is responsible for planning and assisting in the statutorily required periodic physical examination of students conducted by the school physician. She* also assists in, and often actually conducts, the vision and hearing screening tests. She is charged with the duty to ascertain the physician's (whether private or school) findings, to enter these findings in the pupil's cumulative health record, and to make appropriate changes in and recommendations regarding the pupil's curriculum and activities schedules.

Once a specific health problem has been identified, the school nurse-teacher advises the parents of the need for professional attention, counsels the pupil and parents concerning the meaning and impact of the problem identified, informs the family of the resources available to them, and assists in formulating a plan of action. She also provides the staff with information about the problem, assists in modifying the pupil's curriculum, and advises community health groups in regard to the problem identified.

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*(or, nowadays, he)

The school nurse-teacher is responsible for the treatment of health emergencies and may dispense internal medication upon written authorization from the parent and the prescribing physician. In addition, she is responsible for working with the pupil attendance personnel and initiating follow-through measures for health problems related to attendance.

Most important of all, the school nurse-teacher is in an excellent position to deal with drug abuse in a professional manner and within the medical rather than the disciplinary model. While counselors wrestle with the diffuse problems that confront students and parents, in their relationships to each other and to the school, the school nurse-teacher is capable of helping students and parents understand and cope with problems related to substance experimentation or abuse in a non-threatening fashion. Rarely, if ever, is the school nurse feared or avoided. More often, help which she is now too busy or forbidden by school authorities to give is sought in vain by parents and students alike.

A survey of school health programs, conducted in 1969-70 by the Bureau of Statistical Services for the Bureau of Health Service, found that 88 of the 668 school districts within the State employed no full-time nurse-teachers and 514 districts employed no part-time nurse-teachers. One hundred eighty-three districts employed only one full-time nurse teacher and 116 employed one part-time nurse-teacher. Only 96 districts employed seven or more full time nurse-teachers while only 3 districts employed a similar number of part-time nurse-teachers.

Presently, there are approximately 2700 school nurse-teachers employed by the boards of education of New York State. These nurse-teachers service a population of over 3 million students, resulting in an average pupil load of over 1000 students per nurse. In New York City, over 1 million pupils are serviced by 192 part-time and 222 full-time public health nurses and approximately 200 public health assistants. The pupil-nurse ratio is over 2000 to 1. The addition of public health assistants reduces that ratio to over 1600 to 1.

In view of the scope of her responsibilities and the large size of her pupil load, the school nurse-teacher is presently able to function only at a minimal level in the school health program. She is hard pressed for time in which to perform her educational, professional, counseling and clerical duties.

In addition, the school nurse-teacher is often responsible for servicing two or more schools within a single school district. In such cases, a large amount of valuable time is spent in traveling and reorientation. The school nurse-teacher's effectiveness is reduced accordingly.

In order to overcome the physical difficulties faced by the school nurse-teacher and to reduce her pupil load to a more manageable size, additional school nurse-teachers must be trained and, more importantly, hired. These additional personnel will permit each school nurse-teacher to function at a maximal level in health education and counseling.

The school nurse-teacher is also responsible for the performance of numerous clerical duties, including the maintenance of a cumulative health record for each pupil, the written notification to parents concerning an identified health problem and the filing of reports required by the Department of Education. These duties can be performed as well by clerical assistants assigned to the school nurse-teacher.

The previously cited survey found that 578 of the State's 668 school districts employed no full-time clerical staff to assist the school nurse-teacher. Only 187 districts employed one or more part-time clerical assistants. Moreover, as school budgets throughout the State have been cut, clerical assistance has all but disappeared from the school health program.

In order to enable the school nurse-teacher to devote more time to the health related activities for which she is trained, additional personnel should be hired to assist her in performing her clerical responsibilities.

Health aides are also necessary to assist the school nurse-teacher in the planning of periodic health examinations, in the performance of annual screening tests and in the administration of minor first aid. The utilization of such aides will permit the school nurse-teacher to concentrate her efforts upon her area of maximum potential, i.e., the development of an effective health education program and the provision of health counseling and referral services with an ultimate goal of remediating an identified health problem.

We strongly urge the addition of sufficient numbers of school nurse-teachers, health aides, and clerical assistants to realize the potential of this most important category of health professional.

THE SCHOOL PHYSICIAN

Except in the cities of New York, Buffalo, and Rochester, the Education Law §902 requires the trustees or board of education of each school district to employ a competent physician as medical inspector to make inspections of pupils attending the public schools within that district.

The specific responsibilities of the school physician may be summarized as follows:

1. To make a careful examination of all children who do not present a certificate from their family physicians (upon first entrance into school and upon entrance into first, third, seventh and tenth grades).
2. To conduct such special examinations as may be indicated after referrals by classroom teacher or school nurse-teacher.
3. To conduct such special examinations as may be indicated for special class placement or exclusion of the physically or mentally retarded and the emotionally disturbed child.
4. To examine teachers, bus drivers, food handlers and other employees when required by board of education policy.*

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*The Commission submits that this function should pertain only in the absence of private physician care.

5. To examine all students participating in interscholastic athletic activities at the beginning of each sport season and periodically thereafter.

6. To examine applicants for employment certificates and vacation work permits.

7. To work closely with other members of the school health staff in reviewing and maintaining cumulative health records of each child.*

8. To recommend adjustments of the educational program in accordance with individual pupil's health needs and to consult with parents, teachers and pupils from time to time concerning the same.

9. To assist the school nurse-teacher in her follow-through efforts to secure remedial care for children found to have physical or mental defects.

10. To participate with the psychologist, attendance officer, school nurse-teacher and other school personnel in case conferences when such are indicated.

11. To interpret Public Health Laws governing control of communicable diseases and establish policies and procedures governing the exclusion or readmission of pupils in connection with infectious or contagious disease.

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*The Commission submits that this might be more appropriately the primary function of the school nurse-teacher, under the supervision of the school physician.

12. To exercise medical supervision over the hygienic aspects of handling, preparation and storage of food in the cafeteria.*

13. At regular intervals, to make a sanitary survey of the buildings and grounds to detect possible health or safety hazards and to submit a report in writing to the school administrator at least once a year.*

14. To establish policies governing procedures to follow in the event of injury or emergency illness of a child or employee. Printed or mimeographed instructions governing first aid should be signed by the school physician and adequately distributed throughout the building.

15. To review all reports of accidents; to review excuses from any of the physical activities connected with the school program; to review and interpret medical certificates of various types presented to the school administrator.

16. To review on request the health literature used in the school as to its scientific accuracy and recommend indicated action to the school administration.

17. To provide inservice training to school personnel on matters such as first aid, personal hygiene, food handling, etc.**

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*The Commission submits that these functions should be the responsibility of para-professionals, such as health aides.

**The Commission submits that this function might, more appropriately, be the primary responsibility of the school nurse-teacher, under the supervision of the physician.

18. To provide health information to pupils, teachers, nurse-teachers and school administrators.

19. To act as a consultant to school administrators and school health personnel on medical problems and public health procedures.

20. To work with the school administrator on a public information program on school health.

21. To participate actively in school or community health councils.

22. With other school health workers, to share responsibility for informing the public of the school health program through parent-teacher associations, civic clubs and related community agencies.

23. To act as a liaison agent between the school and the physicians practicing in the area.

24. To interpret school health policies and practices to local and area medical societies.

The New York City Health Code, §49.15, states: "A school shall have a licensed physician who shall be in charge of the health care services for the children. The Department shall provide the services of such a physician in public schools and in other schools which request such service."

Each child, upon admission to school, is required to undergo a thorough medical examination conducted by a private physician. If the child does not present evidence of such examination, the school physician will perform the medical examination.

In the event of a medical emergency, the principal (or other person in charge) shall obtain the necessary emergency medical care. The school physician may examine the child when the Health Department feels that the child is in immediate need of medical attention and that delay would be dangerous to health. In either case, the parents must be notified.

The New York City Health Code provides the regulatory basis for employing a school physician. Beyond the mandatory physical examination of pupils and the necessary record-keeping, the duties of the school physician are not specified. It is contrary to both the Education Law and the Health Code for a school physician to provide actual treatment for a pupil. There are supposed to be approximately 300 school physicians (part-time and full-time) operating within the New York City school system. However, in light of recent comments by the new Health Commissioner of the City of New York, a number of these slots are apparently inoperative.*

The Buffalo City Ordinance provides for the appointment of medical school examiners:

> It shall be the duty of every medical school examiner to visit all schools within his district when required to do so by the health commissioner, and examine the pupils in attendance upon said schools for the purpose of determining whether or not such pupils should be vaccinated, and to report to the health department the number of said pupils who have not been vaccinated and who require to be vaccinated; and it shall be his duty to vaccinate said pupils whenever the health commissioner shall so direct. §214
>
> It shall be the duty of the medical school examiners to visit all the schools in the city of Buffalo systematically for the purpose of making such examinations and inspections as may be required by the rules

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*The New York Times, February 6, 1974.

> and regulations prescribed by the health commissioner for this purpose; and they shall perform any other work assigned to them at any time by said health commissioner. The school nurses likewise shall perform such duties as may be assigned to them by the health commissioner. §215*

THE SCHOOL EYE HEALTH PROGRAM

The State Department of Education estimates that one in four children of school age has a vision defect severe enough to require professional attention. A significant number of children entering school (3 to 5%) are found to be permanently handicapped by poor vision or blindness in one eye. About one in 500 school children is legally blind. (A visually handicapped child is one whose vision is 20/70 or worse in the better eye after correction or one whose visual acuity may be normal but whose visual field has narrowed. A legally blind child is one whose visual acuity is 20/200 or worse in the better eye after correction or one whose visual field has narrowed to a 20 degree angle or less.)

The Education Department has determined that it is important for the school to provide the proper environmental conditions which promote good eye health. These include: 1) proper illumination, brightness, and intensity; 2) avoidance of glare; and 3) correct posture for all visual tasks.

The Department strongly recommends that each child be given a complete eye examination at least by the age of four in order to detect early signs of eye problems which may require attention.

For those children who have not had a professional eye examination, community pre-school vision screening programs are run by local health or welfare agencies.

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*Buffalo and Rochester school health programs are discussed at the end of this chapter.

It is the role of the school personnel to work with the community programs to educate parents to the need for and importance of a complete eye examination for the pre-school child. Such an educational program should also include instruction in safety rules for the parent and child in order to prevent pre-school eye injuries.

The school plays no other role in the pre-school program. The school nurse is not responsible for conducting the pre-school screening tests. School facilities are not used for this purpose. It is felt that to permit such practices would a) add to the heavy work-load of the school nurse; b) interfere with regularly scheduled school health program activities; and c) create the assumption that the program is school-sponsored, rather than a community activity.

Having entered the school system, the child is taught the rules for eye health and safety.

Education concerning eye health is an important aspect of the program. The State Education Department recommends that a unit on eye health and safety be included in the general health and safety curriculum for every grade level.

In order to make the vision screening tests a positive learning experience, it is the function of the school nurse to explain the purpose of the screening test to the student during the course of its administration. Moreover, classroom discussion is to be conducted prior to the screening test in order to explain its importance and to deal with questions regarding vision, lighting and safety practices.

School newsletters, radio, television and PTA activities may be utilized to educate parents to the importance of eye care.

Inservice health education for school personnel includes a discussion of the teacher's role in the eye health program.

It is felt that safety instruction is of primary importance since eye injuries are known to be the greatest single cause of loss of vision in the school-age child.

The school also seeks to prevent such injuries during school activities by a) providing eye safety devices for every student and teacher engaged in certain potentially hazardous school programs (as required by Education Law §409-a) and b) alerting pupils and teachers to potential hazards involved in the physical education program.

The school eye health program has as one of its aims the early identification and treatment of eye problems.

To this end, the school provides an annual screening test, as mandated by Education Law §905. The Snellen Distance Acuity Test (the standard eye chart test) is supposed to be administered to each student by the school nurse annually.

For all first grade pupils who have passed the Snellen Test, a convex lens test is recommended in order to detect any refractive errors which have gone unnoticed.

A test for color perception is given to all pupils only once during their school years. The school nurse is responsible for administering the test to all students before entry into high school. The color perception test may be given by the school nurse to any pre-kindergarten, kindergarten, or first grade youngster whom the teacher believes may have a color perception difficulty.

In addition to these vision and perceptual tests, a number of other evaluative procedures are used. A periodic review of the student's cumulative health record by the school nurse may assist in determining whether a professional eye examination may be indicated.

The standard eye tests fall far short of what this Commission believes necessary to prevent learning problems which begin the student on a continuum to failure. Correctable problems such as word blindness, in which whole groups of words disappear to the child, reverse vision, in which the word "saw" appears as the word "was", and poor visual coordination are not detected in the course of these examinations. Nor, in this age of working parents and overworked teachers can the educational system rely solely upon chance observations of visual defects among children. We have seen too many such children in drug treatment programs, Family Court and juvenile detention centers to believe that we can still rely on the fiction that perceptual disabilities do not require specific diagnosis and follow up. That is why we have urged the replication of the P.S. 116 experiment on a statewide basis.

THE SCHOOL HEARING PROGRAM

Material submitted to the Commission by the University of the State of New York, State Education Department, cites a number of studies which document the incidence of hearing impairment among children. One study found that 3.15 percent of elementary school pupils have impaired hearing. An estimated 4.5 percent of the school population need otological diagnosis and about 2.5 percent need special educational assistance.

In another survey it was found that an estimated one million children, including those of pre-school age, have a significant handicap in hearing.

A third study found that there was a high percentage of hearing loss in the elementary school population, with an equally high percentage of loss found among the 10-14 year olds. Possible causes of hearing loss in the older group include parental abuse and prolonged exposure to excessive noise such as: rock music, motorcycles, gun blasts, and power equipment.

The material submitted demonstrates the need for an effective hearing health program by emphasizing the relationship between the ability to hear and the development of speech and language habits. Because a child with a hearing defect may not be able to develop effective speech skills, he may be misdiagnosed as mentally retarded or he may be classified as a "problem child." Severe hearing loss may create emotional and social maladjustment.

The Department of Education advises that: 1) time be allotted for pupil counseling during the course of the screening test in order to explain the significance of the test and to make it a positive learning experience.

2) Time be allotted for classroom discussion of the screening

procedure and for questions concerning hearing and related health education.

3) A program of parent education be developed to advise and assist parents in avoiding or dealing with the hearing problems of their children.

4) Education of teachers include instruction in the scientific aspects of the conservation of hearing program and assistance in meeting the hearing health needs of individual pupils and in developing a plan for health education related to hearing.

This Commission further recommends that Spanish-language hearing tests be made available.

PREVENTION OF HEARING LOSS

Prevention may be considered in three stages. 1) Primary prevention is aimed at the avoidance of any occurrence of hearing loss. This includes those activities noted above in regard to the promotion of hearing health.

It also includes proper environmental conditions in the school, correct safety practices for contact sports and proper emergency care procedures.

2) The second aspect of prevention is detection of hearing loss.

Education Law §905 requires that each pupil enrolled in a public school (except in New York City, Buffalo and Rochester) receive an annual hearing test. The approved screening procedure is a sweep check test administered by means of a pure tone audiometer.

Parents and teachers are encouraged to report their observations concerning the child's hearing health to the school nurse, if there is one available. The nurse will evaluate their observations and periodically review the cumulative health record of the pupil to determine whether professional attention is required.

3) The third aspect of prevention is treatment and educational follow-through. Once the school nurse becomes aware of a condition which may merit medical attention, a number of procedures should be followed.

The nurse should arrange for a conference with the parents in order to explain the significance of her findings and assist in planning a course of action for professional care.

Pupil counseling is important to strengthen the educational impact of the follow-through procedures and to assist in the child's acceptance of responsibility for his own health problems.

Teacher conferences are often necessary to explain the hearing defect and to plan for any curriculum change. Special emphasis should be placed upon instruction regarding the function and care of a hearing aid and the special requirements (e.g. seating) of persons with hearing problems. The Commission finds that all too often the seating arrangement is the only provision made for the child, because of the unavailability of staff to follow up a diagnosis of impairment.

EDUCATION OF CHILDREN WITH HEARING IMPAIRMENTS

Education Law §§3241 and 3242 require a complete census of all physically handicapped children from birth to 21 years of age to be filed annually with the Education Department. (Criteria have been established for the reporting of children with impaired hearing.) The purpose of this census is to locate children who may be in need of special educational services and to provide assistance in the development of vocational guidance programs. Special educational programs should be developed to provide for the needs of those who are handicapped with a hearing defect.

IMMUNIZATIONS

Public Health Law §2164 requires all children (including those in New York City, Buffalo, and Rochester) entering public or private schools, and all children between the ages of two months and six years, to be immunized against poliomyelitis, measles, diphtheria, and rubella. (As of April 17, 1972, immunization against smallpox is no longer required.)

If the parents of an entering student are unable to pay for the services of a private physician, the county physician shall administer the immunizing agent free of charge. (Note, it is the Department of Health which administers this provision pursuant to the Public Health Law. The Department of Education and the school health personnel are involved in immunization only to the extent of refusing admission to those who have not been immunized).

Other states may require various additional immunizations, against smallpox, whooping cough, tetanus, etc. Still others leave the matter entirely to the local school districts.

DENTAL HEALTH SERVICE PROGRAM

The dental health service program is operated under the guidance of the Bureau of Health Service (a part of [illegible] Division of Pupil Personnel Services, which is part of the Department of Education).

The Education Law, §§902-912, permits the local school boards in any district to employ dental hygienists and dentists to conduct dental inspections and other functions related to the dental health services program. These services exist, however, in few school districts, and practically never in inner-city areas.

Every school district employing a dental hygiene teacher in its school program must have a supervising dentist appointed by the local school board. He must be a licensed, registered dentist. He is directly responsible to the school administrator for all dental health service activities.

The supervising dentist performs essentially three functions.

1. He acts as an advisor or consultant to the dental hygiene teacher. That is, he may give the teacher general guidance in how to conduct the dental inspections and may suggest where more or less prophylactic instruction might be used. He also assists the teacher in the selection of materials, equipment and supplies which will be used to foster a better understanding of dental health needs.

2. He acts as an adviser to the school administrator and school health personnel in matters concerning dental health. He may be consulted on such matters as facilities needed for an adequate dental program, dental equipment and, on occasion, selection of new personnel.

3. The supervising dentist is also the liaison agent between the school and fellow-dentists in the community. He is in a key position to assist in the coordination of school dental health activities with those of the community welfare agencies, service clubs and all others interested in children's dental health.

The dental hygiene teacher performs services in four general areas.

1) The teacher conducts the dental inspections and utilizes prophylaxis along with dental health counseling and group instruction.

2) The dental hygiene teacher performs follow-through educational services with school personnel, family and community sources.

3) She assists the classroom teacher and other members of the pupil personnel services in integrating information on dental health into other aspects of the curriculum, e.g. health or science courses.

4) She has the duty to maintain an up-to-date recording and reporting system in order to provide for the intelligent planning of school dental health services and for the effective treatment of an individual pupil's needs.

In order to obtain a provisional certificate (valid for five years), the dental hygiene teacher must have a) an associate degree and b) thirty semester hours of collegiate study toward a baccalaureate degree (including six semester hours of education appropriate to the function of a school dental hygiene teacher). A New York State registration as a dental hygienist is also required.

The requirements for a permanent certificate are a) the successful completion of a four-year program leading to a baccalaureate degree and b) completion of eighteen semester hours of education appropriate to the function of a school dental hygienist.

The classroom teacher, by virtue of her day-long supervision over her pupils, is in a key position to a) foster the development of good dental care habits and b) observe possible signs of oral ill-health.

The classroom teacher may obtain assistance from the dental hygiene teacher in selecting educational materials which promote proper dental hygiene habits.

She should refer children she suspects of having dental handicaps to the dental hygiene teacher.

These materials treat dental health services for handicapped children as an area of primary importance. These children may have such handicapping conditions as: cerebral palsy, cleft palate, dento-facial (e.g. orthodontic) handicaps, speech disturbances, diabetes, epilepsy, cardiac conditions and mental retardation.

Proper dental health care is essential for handicapped children because a) primary medical and financial focus is often placed on the handicapping condition to the detriment of proper dental care and b) oral defects in handicapped children may be potential foci of infection and may contribute to the severity of the handicapping condition.

In order to encourage desirable eating habits and adequate food selection practices, the S.U.N.Y. recommends that the local school authorities, in addition to providing for health instruction concerning proper diet and nutrition, initiate a program to restrict the sale of candy and soft drinks containing refined carbohydrates on school property.

It is felt that the restriction of sugar is effective in the control of dental caries and will improve the diet and nutrition of the pupil.

It is important to note that this is merely a recommendation. The legal power to regulate procedures within a school rests with the local school authorities.

Sections 902 and 909 of the Education Law do not, on their face, require a local school district to employ a supervising dentist or a dental hygiene teacher or to provide for instruction in dental health.

However, the Regulations of the Commissioner of Education governing health services, §136.3 make it the duty of the trustees and boards of education to provide dental inspections and/or screening.

Moreover, the boards of education may, where exigencies warrant, provide treatment when the child would otherwise be deprived of the full benefit of education because of the dental problem.

BUFFALO SCHOOL HEALTH*

School health programs in New York State continue in the traditional patterns as defined in the health services section of the State Education Law. New York City, Rochester and Buffalo were excluded because these cities had established health departments providing school health services when the State laws were enacted in 1910. This has permitted more freedom in development of new services in these urban programs and allowed some departures from the State law. An illustration was the development of periodic rather than yearly physicals in these cities long before the State eliminated the requirement for annual physical examination.

During this century, there has been marked improvement in the health of children as a result of improved nutrition, higher living standards, control of a number of diseases, better medical care and improved rehabilitation services. As a result, children enter school with serious physical defects corrected or improved as a result of the medical rehabilitation program of this State. Unfortunately, funds have been curtailed by the State in the last two or three years, and many counties have markedly reduced or eliminated funding for many of these conditions.

Although children are generally healthier today, we still have many problems facing us such as mental health conditions, drug abuse, out-of-wedlocks, venereal disease and the chronically ill. There is much to be done and the traditional school health program needs to be overhauled. The system which served us well in the first half of this century is not meeting our current problems.

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*Verbatim statement on school health before a Hearing of the State Commission to Evaluate the Drug Laws by William E. Mosher, M.D., Commissioner of Health, Erie County Department of Health, on October 24, 1973.

In the city of Buffalo, traditional health care is provided in most schools with routine physical examinations in the entering grade and the sixth grade. In addition, there are examinations for students participating in sports, working paper applicants and students in special classes. In addition to physical examinations, screening is available for vision and hearing defects, dental defects and color blindness.

Special Title I and Model Cities funded programs have provided additional staff to permit additional services in selected low income area schools where lead poison and sicle cell disease screening and urine protein and glucose are also done.

In addition, students with a wide variety of complaints come into the school health office, some complaints are valid but many students use the school health service as a means of escape from the chores of classwork.

Large numbers of deficits are identified but as Vanhaver and others have shown, the value of defects found in routine, casually done exams is often of questionable value. In the 1972-73 school year, adequate reports were available from nurses working in 66 schools, (60 elementary, 2 junior high and 4 high schools).*

The following was reported (numbers rounded off):

Physical Exams Done	5000
Physical Defects Identified	800
Children Referred for Care	540
Effective Referrals	250
No Information	250
Parents Refused to Follow Up	40

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*Public school census: K-8 = 41,261; 9-12 = 19,087; "Early Push" Pre-Kindergarten = 749; Total = 61,097. Catholic Diocese: K-8 = 17,803; 9-12 = 15,565; Total = 33,368. School nurses: 112 full-time; 36 part-time.

A wide variety of defects were identified, but the majority were vision or hearing deficits. The number of children with defects reported from the above schools are as follows (listed in order of frequency):

Large tonsils	44
Dermatitis	44
Heart murmur or arrhythmia	40
Acute infections	37
Umbilical hernias	23
Orthopedic problems	20
Earwax	20
Under or overweight	14
Undescended testicles	11
Possible anemia	11
Emotional problems	11
Warts	8
Foreign body in ear canal	3
Diabetes	2
Hypertension	3
Child abuse	2
Wilm's tumor	1
Miscellaneous-benign	24

The most significant defects identified above were probably not found in children who had a routine screening but were referred for a variety of reasons.

A few children with serious illness obtain therapy through the assistance of the school health program. There is no way of knowing how many other students benefited from the health counselling.

Reliable information is available for some of the other health screening services. The hearing screening program produced the following:

Number of students screened	32,000	
Hearing defects found	889	
Good follow up data available	197	
No. with definite ENT* inflammation	119	(60%)
Possible infection or defect	28	
Sensoroneural hearing loss	18	
Tympanosclerosis	1	
No defect or disease	18	

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*Ear, nose and throat

Dental screening was provided for 19,000 students of which 11,000 were referred for further care and 7,[illegible]00 caries free children had dental prophylaxis in school. Active dental education and other preventive services including a tooth sealant program was provided along with the screening and treatment. Definitive dental care was provided for approximately 8,000 students.

Perhaps the most aggravating and frustrating problems which we have been involved with has been the control of pediculosis or head lice. In some schools, up to 40% of all children are infested and the problem is ubiquitous. This defect, if you can call it that, has required that the school health service cross its traditional barrier and actually treat, but a great deal of time and effort is necessary if this widespread and aggravating infestation is to be eradicated.

Other health screening programs in schools are or have been considered. Urine screening for protein and sugar does not seem productive. Screening with urine cultures is more effective but hard to institute. Routine tuberculin screening is no longer indicated in our area because of the low incidence of tuberculosis.

Hypertension screening appears to be a very effective first step in the prevention of disability later in life and we are now just getting our feet wet in this area. Here again, the screening is relatively simple but some very real problems are posed for which there are no good answers: When do you refer someone whose blood pressure is intermittently elevated or elevated once: After they are referred what must the treatment program provide as an adequate evaluation: What do you tell an adolescent about his transiently elevated blood pressure and what kind of follow-up is indicated. A carefully monitored referral and follow-up program is a must for this confusing and ubiquitous disease. It is important that diagnostic and referral programs result in meaningful health information and treatment and not cause fear and needless treatment.

The school health program also provided a number of other health services including:

17,400 immunizations
Limited health counseling
Limited health education and much record keeping

The cost of these services are as follows (estimated from 1972-73 data):

Nursing services	$350,000
Physician services	150,000
Hearing technicians	64,000
Dental program	234,000
Supplies	100,000
Total	$898,000

Cost per student: $10/student

Thus, this school health screening program is a relatively inexpensive program. But is a health screening program adequate? The school age child is the least likely to obtain health care and major unmet needs exist. An estimated 10 to 15 percent of students have significant mental health problems. Mental health services for the young are markedly deficient and so poorly coordinated and understood that a great deal of duplication and confusion exists. However, the Erie County Mental Health Department is developing a comprehensive system for addressing the problem of children.

Twenty-five percent of the infants born in low income areas are born to school age mothers (19 years of age or less) but there are very limited resources for sex education, family life and parenthood education, health care services and the wide variety of supportive services needed by adolescent parents.

There is a serious need for more adequate school health services for chronically ill students. The survival rate for chronically ill children has improved and there is a greater awareness of the need for normalization of all children - the handicapped, chronically ill, retarded, and so forth. This places a greater burden for the school for the teachers must understand the children, their problems, and how to respond to them and this counselling aid guidance must come from the school health staff. Without it, the students are exposed to discrimination and mismanagement which only compounds their problems.

There are other problems in the traditional school health programs as a result of poor staff training and utilization. A survey of school nurses working in schools done in 1971 showed many problems in staff utilization. Seventy-five percent of the nurses felt that they spent a significant portion of their time doing record keeping and other clerical work. First aid and assisting physicians with physical exams were the other major responsibilities. Only 30% of the nurses felt they spend a significant amount of their time in counselling and referral for health problems and only 15% were significantly involved in counselling and referral for emotional problems and health education. Seventy-five percent of the staff felt they should be spending more time in these latter three areas. Almost 100% of the nurses felt that many of their more routine chores should be done by lesser trained staff thereby allowing them more time for more meaningful work.

Diagnostic services for a wide number of conditions either financed through Health Department funds or by hospitals with state aid assistance. The Erie County Health Department is providing the following special services for all school children in Erie County:

Ophthalmalogic consultations
Periodic screening clinic for Medicaid
Hearing Diagnostic services
Cleft palate clinic - operation of Erie County
    Health Department and Childrens Hospital
Rheumatic fever clinic
Cardiac diagnostic clinic
Venereal disease clinic
Tuberculosis clinic
Teenage clinic for children who are pregnant or
    have other social and health problems
Sickle cell screening
Lead control clinics
Orthodontic screening
Specialty clinic for children with mental retardation or learning disabilities

In addition, specialty services are available through the Children's Hospital, other hospitals and voluntary agencies.

These include:

Cerebral palsy
Epilepsy
Brain injured children
Kidney disease
Multiple sclerosis
Muscular dystrophy
Diabetes
Many other conditions

The Erie County Health Department and the Department of Social Services are currently developing a comprehensive program for early periodic screening of children under 21 who are eligible for welfare or Medicaid. There are an estimated 55,500 in this group. A screening program is currently operating at County Hall which provides a comprehensive examination for pre-schoolers under this program. This will be extended to include other children through private physician referral and Health Department services in the schools or in the two health centers of the Department. The Health and Social Services Departments will insist on adequate follow-up to make sure treatment is obtained. A computerized service is being developed to insure that eligible children are offered this service and are followed. This will insure adequate medical care for a large segment of the population at risk.

It is also the intent of the Health Department to provide comprehensive health services to the schools in the vicinity of our two health centers - one in the City of Lackawanna and the other in central Buffalo. This will provide a comprehensive health program to a large group of low socio-economic pre-school and school children and will include preventive, diagnostic and treatment services.

Another substantial barrier to providing adequate health services is that there is a substantial group of school children who are near-indigents and not eligible for Medicaid. It is my opinion that many of these families are too proud to seek medical care unless their child is seriously ill. This problem needs further study and should be addressed by this Committee.

In conclusion, a metropolitan health department is able to provide a wide range of services to school children unlike school districts which are not permitted to practice medicine. The services of the Erie County Health Department are far from ideal and need strengthening in many areas. More training for our nursing staff is necessary because of the counselling demands which are increasing. Nurses should be relieved of non-nursing duties. Teachers need additional training in order to develop closer cooperation between health services and educational personnel in solving pupil health problems.

I have the following recommendations:

(1) A State-wide committee to review the school health program and make recommendations for changes in legislation and to develop new goals and programs for school health. Special consideration should be given to the appropriate agency to provide health services in the schools.

(2) The liberalizing of financial support to counties for the crippled children's program. I would recommend open-ended State aid at the 75 percent level or even higher.

(3) State-wide implementation of the periodic screening and treatment program for children under 21 eligible for Medicaid.

(4) Hypertension screening for school children.

(5) Substantial increase in State aid to support school health services.

(6) Training program for school health personnel in health counselling.

(7) Utilization of nurse practitioners or public health nurses to replace physicians in the screening and counselling program. The physician should be available as a consultant.

(8) The support of screening services through making available diagnostic programs for hearing, vision and heart disease as an integral part of the school health program.

(9) Expansion and support of dental treatment services for indigent or near-indigents.

Dr. Mosher states: I have included in this statement materials prepared by Dr. Kay Harrod, Deputy Commissioner of Maternal and Child Health, Erie County Health Department.

ROCHESTER SCHOOL HEALTH*

Rochester City School District - Public and Parochial Schools: Health services to schools are rendered by the County of Monroe Health Department in conjunction with the Pupil-Personnel Division of the School District.

Diagnostic and referral services are available to school children as any other group of citizens in the school. Hearing and vision teams screen youngsters for deviations from the normal. Nurses follow up for referral to private or ambulatory services in the field of ophthalmology. An audiologist examines children and makes referrals to private or ambulatory health centers for treatment. Further testing and treatment would be obtained through the Rochester Hearing and Speech Center.

The nurse in the school reviews the students' physical status and makes referrals to community health facilities, private physicians, or ambulatory centers for further diagnosis and treatment.

Emphasis is placed on continuity and comprehensiveness of care. Families are urged to be registered for family and individual care in a community health service.

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*Statement on school health before a Hearing of the State Commission to Evaluate the Drug Laws submitted by County of Monroe Department of Health, Division of Public Health Nursing.

Immunizations are given in the schools by the nurse as needed.

Mental health services are rendered by School Mental Health Teams in conjunction with Community Mental Health Centers - Children Divisions.

Athletic and work permit physical examinations are provided by the County of Monroe Health Department. Venereal Disease is also treated by the Health Department.

Deviations Noted:

Defects noted were referred by teachers, families, physicians and nurses.

General defects 2,168 - 3.7%. Approximately 50% of these were known. 1,040 defects were referred for medical care.

Vision defects: 3,085 or 11% of those tested (27,007)

Hearing defects: 968 or 10% of those tested (9,758)

Total school population - approximately 57,000

SCHOOL HEALTH PROGRAM
City School District

STRUCTURE AND ORGANIZATION

The County of Monroe Health Department provides school health services to the City School District and parochial schools in the city. A total of 92 schools are served.

Medical and nursing direction and administration are provided by a Medical Director in the maternal child health program of the County Health Department and an Assistant Director of Public Health Nursing. They work in cooperation with the Director and personnel of the Department of Pupil Personnel in the City School District and the Diocesan School Office.

The school health services are specialized in the Health Department. All nursing and aide staff function only in the school health program on a ten-month basis. A few nurses work in the generalized program, when schools are out of session, to keep themselves updated in public health nursing.

The Health Department provides, in addition to the physician and nurse administrator, the following personnel:

2 Supervising Public Health Nurses
34 Nurses
5 Health Office Assistants - practical nurses
28 Full time Health Aides
10 Part time Health Aides
1 Part time Physical Therapist
Mental Health Consultant
5 Part time Pediatricians
2 Medical Consultants in Otology
Vision/Hearing Teams
    3 Full time Aides
    1 Full time Nurse
      Also, contract for speech and hearing consultation
1 Clerk

Other consultant and educational facilities of the Health Department are put at the disposal of the schools, i.e.; venereal disease visual aids and educational personnel.

QUALIFICATIONS OF NURSES AND PERSONNEL

The administrator and supervisors are all qualified public health nurses with Baccalaureate and Master's degrees.

Approximately 15 of the 34 staff nurses are public health nurses, having additional university study and having their Bachelor's degree. The remaining 12 nurses are graduate nurses with no university study. The 5 health office assistants are practical nurses. The health aides are primarily trained on the job.

ASSIGNMENTS

In some cases, one secondary school and one small elementary school are assigned to one nurse, who also has a full time aide. In other cases, from one to three elementary schools are assigned to a nurse. The number of schools assigned depends upon the number of students and the physical and psycho-social problems. Depending upon the needs of the school, a health office assistant or health aide is assigned on a part time or full time basis.

PHILOSOPHY OF THE PROGRAM AND SERVICE

We believe every child and his family should be associated with a primary comprehensive health facility. This may be a private physician, a health center, a hospital ambulatory health center, etc. Hence, we are attempting to eliminate routine services and provide more selective and intensive service for those in need. For example, we have eliminated superficial health appraisals. Children are urged to attend a primary health center only in those cases of extreme need for physical examination. Pediatricians for the school will provide a more extensive examination.

Emphasis is placed on teacher-nurse conferences to select youngsters with health problems, learning disabilities, emotional problems, etc. The nurse is expected to develop a care plan in conjunction with appropriate personnel in the school or health service. It is the nurse's responsibility to work intensively with the student and his family to accomplish a suitable disposition of the student's problems.

Immunizations are provided by the nurse as indicated.

The nurse also provides individual counseling to students and teachers. She assists and participates in the process of planning and implementing health education. She is encouraged to develop group work when and where needed, and is being developed as a group leader.

The nurse ties in closely with neighborhood health centers in order that there be a coordinated and continuous flow of data and plan of action to help individual students and families. This relationship is being developed on a demonstration basis.

Our school health hearing and vision teams do all the testing in schools, day care centers, and nurseries. The school nurse does all the follow-up.

FUTURE GOAL

We hope eventually to have approximately 75-80 health aides. The health aides assist with day-by-day first aid, triage and record work.

Nurses will be divided into two groups:

1. A limited number of pediatric school nurse practitioners. These practitioners will screen in more detail selected children needing care. They will work closely with the primary medical facility caring for the child. They may even administer treatment and drugs under the aegis of the medical facility. In this way, children may receive more efficient and better care in those cases where parents are willing to have the care but are unable to motivate themselves to action. In no way will this be a substitute for parental responsibility. The child would first be seen at the primary health center.

2. Remaining nurses will be qualified public health nurses, well fortified in the psycho-social aspect of care. They will be well qualified clinicians, as well as having additional preparation in health education.

With the increase in health aides, the overall numbers of well prepared nurse practitioners and public health nurses will be reduced.

However, overall costs will either remain the same or be increased. Hence, the development of this type of program must be considered a part of the health care system and demonstrate the effectiveness of clinical and educational health care for the school-age child. The services will need to be more selective in relation to a specific child and less diffusive. Health education and service should complement each other. Children should be helped to assume increasing responsibility for their health as they progress in school.

School health, unfortunately, has become a misnomer. School health is a packaged deal for all, rather than personal and selective. Moreover, there has been no real accountability for what is or has been or needs to be accomplished. School health serving our manpower, leadership, and citizens of tomorrow, should be the most challenging and dynamic of health services. It should be interwoven into the health delivery system.

EARLY AND PERIODIC SCREENING

The federal government enacted legislation in 1968, which made children eligible for Medicaid also eligible for early and periodic health screening on a state-federal matching fund basis. Until 1971, the Department of Health Education and Welfare had issued no regulatory guidelines for the states to implement this program, and until 1972, no plans for state implementation had been drawn.

Early periodic screening was envisaged as a program to provide, out of Medicaid funds, health programs to find and treat deafness, eye defects, rheumatic hearts, spine curvatures, anemia and other ailments that welfare-eligible children suffer in greater proportion than other youths. The slowness of the federal and state authorities to move on this program has been attributed to cost. For example, New York State's Department of Social Services has offered to pay $20 per examination, while some hospital clinics and treatment centers seek $30. However, philosophical and bureaucratic problems also appear plentiful: Although the program is designed as preventive medicine, it is administered as part of welfare by Social Services, with standards approved by health officials. There is serious concern over whether the pressure to reduce welfare rolls conflicts with the need to seek out and identify children eligible for screening. Moreover, the lack of screening for near-indigent and middle-class children seems grossly unfair, particularly in light of the woeful neglect of the health of so many school age children under the extremely lax enforcement of state education law school health standards.

Moreover, as noted earlier, there has always been a continuing dispute regarding the role of the schools in the field of preventive medicine, and to what extent the schools should be the entrance point for families to community health services. In New York City, 77 Child Health Centers are equipped to provide early and periodic screening for welfare-eligible children ages 0-21. In the event further diagnostic work and treatment are deemed advisable, parents are referred to more particular health agencies or physicians. Of the estimated 750,000 to 900,000 eligible young people, to date, 80,000 have been screened. Of the 250,000 eligible children ages 0-6, 50,000 have been seen; however, there is no data regarding how many of these children were already known to Child Health Centers and, therefore, were not being given anything they already had not received. Children in foster care have been seen separately, and are not included in these figures.

The effort to use this program to substitute for school health screening has been a dismal failure. Parents have not been informed of the existence of the program; they have not had the time or the interest to make use of it when they knew about it; and some school officials have not cooperated in giving students time off to obtain their screenings.* The exploratory program in "one or two" schools, which would place initial screening and diagnosis on the school premises in New York City is a response to this situation by the new City administration. Upstate, where an additional 500,000 are eligible, very little has yet been accomplished.

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*Facts provided by the Citizens Committee for Children.

CONCLUSIONS

The Commission finds that the continuum to failure, which lowers the self-esteem of young people, and ultimately causes them to be unemployable and to engage in a variety of modes of destructive and self-destructive conduct, including substance abuse, begins with a variety of conditions, the effects of which can be effectively arrested and remedied in the school system. Four techniques appear to hold the greatest promise in this regard:

First, we find that the learning process can often be aided by scaling the educational unit down to a manageable size. The proviso we offer, however, is that improving the scholastic achievement of the individual student must be the goal, rather than stimulation of interest and increased contact with staff, without specific attempts to develop increased academic skills.

Second, we find that health screening, particularly with regard to conditions directly affecting learning, such as perception, should be available to all students, regardless of income. Actual treatment of diagnosed conditions should be provided on the basis of need; however, detection of learning impediments is so often overlooked by parents and teachers, even with regard to middle-class and near-indigent children, that these services should simply be available to all in the same way that public education, itself, is available to all. We see little purpose in demanding that the state teach children to read, write and calculate, when hundreds of thousands of them are unable to do as well as their natural endowments would permit, because of learning disabilities, short of gross handicaps, that go undetected until the child becomes involved in a serious behavioral difficulty. We strongly urge the implementation of the screening techniques used by the N.Y.U. Learning Disorders Unit at P.S. 116 throughout the state, and, to the extent practicable, within the framework of community provision of health care, we support school-based diagnosis under the early and periodic screening of children program.

Third, we find that the key to continuing good health practices among school-age children, the essence and core of their respect for the integrity of their own physical well-being, and a substantial preventive to substance abuse, is the availability of competent school-nurse teachers, health aides and assistants in the schools and as liaisons between school, home and providers of community health care. We find a severe lack of such personnel and, therefore, we recommend substantial increases in their numbers.

Fourth, we find that competent guidance counselors are not free to help students and families deal with learning difficulties which result from personal problems, adjustment difficulties and unclear career choices, because of the sheer case-load burden of each counselor. We admire the efforts of the street-workers at Haaren to help students in this regard, but we believe that the state should provide more fully trained counselors in the schools, with greatly reduced caseloads. No child in the State of New York should have to take drugs or become intoxicated with alcohol in order to have attention paid to his personal or family problems.

Fifth, while we view counselor confidentiality as an incident of personal discretion, based upon the relationship between counselor and student, rather than as a legal right to be protected by statute, we also view the medical records of students as sacrosanct: In the event that greater efforts are to be made in the schools to diagnose health problems, the need for well-kept records, inviolate to discipline authorities, must be recognized.

CHAPTER IV

DELIVERY OF COMMUNITY HEALTH AND MENTAL HEALTH SERVICES

Drug abuse is one way of compensating for low self-esteem; and a child's self-esteem is based at least in part on the level of care which his family, his school and his community provide, since this demonstrates to him how much he is valued. Therefore, as part of a drug abuse prevention effort, it is necessary that all children receive proper health and mental health care. A child should never get the message that in order to receive care, he must first abuse drugs. However, this Commission finds that the problems of inaccessibility, discontinuity, and lack of follow-up which cripple the school health programs are magnified in the general community health and mental health field. The major weakness of the present system of delivery is the same as that which caused confusion about the goal of drug abuse prevention: concentration on symptoms rather than on people. Services are offered only after a problem has become an annoyance to others, i.e. the withdrawn child is not referred for help, only the acting-out child, if anyone is. Preventive care, except in the sense of public health inoculations, is rarely offered. This funding priority which stresses care in crises results, as it does in every human service field, in people suffering needlessly and services costing more than they should.

The almost tragicomic story, known to every health professional, of the mother who brings her infant, ill and running a 104-degree fever, to the well-baby clinic in her neighborhood where the child is known, only to be told "We treat well babies. Your child is sick. Take him to the pediatric clinic three miles away" exemplifies the problems created by overspecialization and fragmentation.

GAPS IN SERVICE

In 1970, Ana Dumois, Director of the Community Health Institute of New York City, listed complaints of low-income area health service consumers, as follows:

> "People do not have a single doctor they can relate to, and emergency rooms have taken the place of personal physicians.... The care in hospital clinics and health centers is often undignified, and there are long waits, discouraging people from getting even the health care that is available.... Clinics are in a sense worse than emergency rooms because the care is fragmented.... Clinic hours and procedures are arranged for the convenience of the staff, rather than the needs of the patient.... Record keeping is poor, resulting in even longer waiting time for patients and repeated tests because records are either lost or non-existent.... Patients are not told what's wrong with them, leaving them with a sense of insecurity.... Prescriptions are given, but the patient is not told what they are for, and very slow service in the pharmacy results in one more obstacle to health care.... There is no division in the clinics between those who come for minor ailments and those who are seriously ill.... There is a lack of preventive health services.... There are few full-time physicians in clinics.... There are widespread complaints about inadequate ambulance service.... Patient records are not transferred when they go from one facility to another.... The patients cannot distinguish one person from another: Who is a nurse? Who is a medical student? Who is a physician?.... Clinic patients are demoralized when they see private patients getting better treatment."*

Shortly thereafter, the Mayor's Organizational Task Force adopted the proposals of its Problem Areas and Priorities Committee with the following preamble:

> "Although this country spends proportionately more on health than any country in the world, we are confronted with major inadequacies in our health care organization and

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*Health Planning, publication of the Mayor's Organizational Task Force for Comprehensive Health Planning, October - November, 1970.

delivery system. [New York City] is in an odd position. We have the greatest concentration of superior medical technology in the world and although some shortages exist, in the aggregate we have an enormous concentration of professional personnel. New York City also has....by far the largest system of public medical care in the country.

"Adequate preventive, therapeutic, and rehabilitative care is not available to many of our citizens at levels of day-to-day community practice, either through care at home or in institutions. It is our firm conviction that whenever possible people should receive health care outside of an institutional setting. Large numbers of people - the poor, the aged, the isolated, the non-white - receive few of the benefits of modern medicine even though because of poor health they generally require more care than do more privileged groups. Middle income groups in our city also are affected by a disjointed and inadequate health care delivery system. The environment of our city - its air, water, cleanliness and health aspects of housing - is a vital part of comprehensive planning for health. It is essential that we place a high priority on the environment in which we live and on personal health services....

"Ambulatory health services are frequently crisis-oriented, discontinuous and non-comprehensive.... In a well-organized system of health care, every individual should relate to a health professional who has access to the individual's past history and who can develop a personal relationship with him....

"Another vital component of high quality medical care is a periodic health inventory for every citizen. Such an inventory will show up previously undetected disease through laboratory tests, physical examination, and by taking a thorough history....

""The health inventory could succeed only if it is supported by a program of health education which would persuade people to make use of the health opportunities available to them. Medically indigent people are accustomed to crisis medical care, and must be taught the value of preventive health examinations for themselves and their children."*

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*Health Planning, publication of the Mayor's Organizational Task Force for Comprehensive Health Planning, October - November, 1970.

The Task Force published examples of the results of lack of coordination:

> "In one area, the district health center, the pediatric clinic of the local voluntary hospital, the local Head Start group, and the school health service, each plan a drive for immunization of children against German measles. At no point do any of these agencies get together. The result: some children get their shots 2 or 3 times - some not at all.
>
> "Two neighboring hospitals each set up expensive units for treatment of patients with chronic kidney disease - at no time consulting each other. Meanwhile, neither hospital provides adequate emergency room or clinic care for local residents in the area they serve.
>
> "A comprehensive child care center refers one of its patients to the mental health center located across the street. But the pediatric center and the mental health center each serve different geographic areas, and the child is forced to travel several miles to the unit that serves his area."*

What these gaps in services mean to children is reflected in the following data on physical defects of children admitted for care at the Mission of the Immaculate Virgin, a residence for children requiring placement away from their own homes:

> "The proportion of children found on intake physical examination to have untreated medical problems the first six months of 1973 was high.
>
> "There were 99 boys and 35 girls admitted from January to June. Physical defects noted were as follows:

Umbilical hernia	5
Systolic murmurs	5
Parasitic infestations	7
Sickle Cell Trait or Disease	8
G.U. Problems	
Undescended Testicles	4
Phimosis	5
Varicocele	1

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*Health Planning, op. cit. Aug. 1970

Diminished hearing	8
Strabismus	5
Orthodontic	8
Severe Obesity	3
TB Contacts	12
Prosthetic eye (not replaced in 8 years)	1
Foot problems	6
Orthopedic Problems	
Scoliosis	1
Kyphosis	1
Osgood Schlatters	6
Poor Visual Acuity (no glasses)	15
Hypertension	1
Carious teeth	1
Enlarged Tonsils	15
Speech Impediments	12" *

All of these conditions, with the exception of sickle cell trait, are treatable. All of them affect a child's capacity to function in school. The obvious school handicaps of diminished hearing and poor vision are already statutorily intended to be checked in school. The child with the prosthetic eye which had not been replaced in 8 years, despite probable changes in the size of eye socket, certainly was known to a health service provider. One wonders how it could have happened that there had been no follow-up. Failure to bring a child for health care may not always indicate purposeful neglect, by a family. It can indicate ignorance as to the necessity for such care, not understanding that the care can really make a difference, can help; failure to understand that

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*Fogarty, Rev. Msgr. Edmund F., Director, Mission of the Immaculate Virgin, Mt. Loretto, Staten Island, N. Y., Letter of 9/20/73.

lack of care can hurt. Such misunderstanding can be clarified by staff of a health service agency, on a home visit, and this is a job which a paraprofessional can do admirably. Where there is true neglect, it may be necessary for a health service staff person to himself bring the child for the required service. These services are not frills. They are essentials.

In the area of mental health services for children, the picture is equally bleak. There is not one mental health service for children in the Williamsbridge catchment area of the Bronx, and the only single such service in the entire Northeast Bronx is Bronx State Hospital.* The Bureau of Child Guidance, which theoretically picks up those children identified by school personnel as in need of mental health care, has 5-1/2 part-time psychologists serving the 50,000 children in the school district of the Northeast Bronx. They confine their service to testing and diagnosis. But suppose a child needs treatment? The waiting list for the voluntary agencies providing such care is three to six months.** Those children who do get referred to Bureau of Child Guidance are the unruly ones or those with bizarre behavior. The children who are withdrawn, the family facing a temporary crisis, the family which has many strengths but is slightly disorganized and perhaps scapegoating a youngster, these are not even counted among the statistics of families awaiting care. They are lost. There is an almost wistful comment on this situation in a letter dated October 18, 1973, from a Board of Education high official:

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*Interview; Sister Anne, Director, Astor Home for Children, 2/25/74.

**Ibid.

> "It seems to me that staff should be made available in every elementary school to whom troubled children could be referred for intensive analysis and assistance."*

The quality of care provided the middle class depends largely on the patient's own sophistication in medical matters. The wealthier find they must move from specialist to specialist, rarely receiving the thorough comprehensive examination and testing which might reveal underlying causes for a variety of symptoms. The middle class is unable to pay for extensive private specialists, is unable to find old fashioned "family doctors," or generalists, and is unable to obtain reimbursement, under many health plans for diagnostic work or for preventive care, such as periodic annual examinations. New York State's own health plan for state employees does not reimburse for such periodic evaluations.

The extent of the longing for medical care by one doctor who personally knows the patient, in other words, for continuity of service, is hinted at in a study conducted by the Medical College of Georgia in Augusta, which revealed large numbers of city dwellers traveling up to fifty miles to practitioners in small towns, for their medical care. A study of the patient group of

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*Polatnick, Samuel, Executive Director, High School Division, New York Board of Education.

119 rural doctors revealed that 10% of their patients came from cities, although each doctor practiced in one of 26 towns studied, each of which was at least 25 miles from the next nearest town, with some doctors servicing a patient group in which as many as 20% came from the city. The doctors suggested that urbanites might be seeking to avoid the "ping pong system of medical care" in which patients bounce from one specialist to another in an uncoordinated, haphazard manner. While large cities have a plentiful supply of specialist services, the doctors said, they do have a serious shortage of the basic, broader medical services that are most frequently needed by all groups of people.* The researchers contend the same trend has affected eastern New York State, as well as elsewhere.

The Commission received numerous comments, in response to its letters of inquiry, regarding the dearth of good medical care and the connection between this lack and the prevalence of drug abuse. Captain Lorraine D. Kuhl, Director, Salvation Army, wrote:

> "Within the context of drug abuse prevention - preventive medicine means provision and utilization of medical care from infancy, as well as provision and utilization of therapy for parents and, if necessary, for the family constellation. Observations indicate huge gaps in both medical care and psychological care of residents - with untreated problems in every category from physical to psychological....

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*New York Times, Feb. 18, 1974, p. 15. Report of study by Dr. Glen E. Garrison, Dr. Warren H. Gullen, and Connie M. Connell.

> Tremendous educational impairments regarding basic reading and math."*

Professor Charlotte Muller offered suggestions regarding adolescent medicine:

> "In addition to indirect prevention of drug abuse, health services that are appropriate for young people need to be developed. Adolescents should feel that a program cares about their total health and well-being and respects them as individuals. We have studies that show the state of health in the teen years and the feelings of young people about their health. Programs should be based on such studies and should involve the youth continually in evolving the specific range of the services, the schedule, and the style and atmosphere of service.... Training, employment and other service referrals should be offered and the users of health services should be surveyed to find out what other services are needed.
>
> "It is discouraging to see punishment and threats used again and again after so many showings of failure to break addiction. In fact, it seems that the punitive approach worsens drug epidemics and raises the direct and indirect costs of drug-taking. We need more research in methods of treatment that are non-institutional and fairly compatible with ordinary living."**

SOME MODEL PROGRAMS

I. Adolescent Medicine:

There have developed a number of innovative programs which aim to offer teenagers a comprehensive service, to aid in whatever difficulties each sees as his problems. These programs are usually walk-in storefront types, and include remedial education, counseling, both individual and group, and a gamut of medical services.

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* Kuhl, Captain Lorraine D., Director, Women's Narcotic Treatment Center, The Salvation Army (N.Y.C.), letter, October 27, 1973.

**Muller, Charlotte, Professor, Center for Social Research, Graduate Center, City University of New York, letter, September 4, 1973.

There are in New York City two "Free Clinics," which are walk-in clinics providing a multiplicity of services to the 16 - 25-year-olds. One is The Door, at 12 East 12th Street, funded by the National Institute of Mental Health and headed by Drs. Lorraine Hendricks and James Turansky. They are open 6-10 p.m., Tuesday through Thursday, and offer medical care plus legal and educational services, vocational guidance, group therapy, dramatics.

They use their medical care as a means of gaining entry to explore all problems the patient may have, with a view to intervening, where necessary, in his life-style. For instance, should a patient come in with a medical problem, he is asked what he is doing, in general. If it turns out that he has been unable to find a job, he is referred for vocational guidance. If his problem is legal, such as pending eviction or criminal prosecution, he is referred for legal services by an attorney or a supervised law student.

Many of this age group would never think of going to a lawyer and might not know where to turn for vocational help, or would be put off by a large bureaucratic set-up.

The second free clinic is the St. Mark's Free Clinic, on St. Mark's Place.

There are also a small number of Adolescent Medicine Services in hospitals.

In New York City and environs, there are ten Adolescent Medicine Services, but only four are full-time and deal with the total patient. These are: Montefiore, Roosevelt, Mount Sinai, and Long Island Jewish Hospitals (this last is in Nassau).

There are less comprehensive services at Bronx-Lebanon, New York Hospital, Beth Israel, and Bellevue. In addition, St. Vincent's and Brooklyn Jewish have a clinic operating one or two afternoons a week.

In the area adjacent to Montefiore Hospital, in the Northeast Bronx, there are 16,000 adolescents in school (Lehman College, Bronx High School of Science, Evander Childs High School, and two others). The only Adolescent Medicine Service in the area is that of Montefiore Hospital, with 32 beds. Montefiore offered to pub a medical teacm "on site" in a school. The Board of Education said they had no funds for this. The City Department of Health said it was short of funds.*

Adolescent medicine as a specialty is only about ten years old, and came into being with the loss of the general practitioner. There are a number of medical problems particularly prevalent among adolescents. The old-fashioned general practitioner became familiar with them in the course of his general practice.

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*Interview with Dr. Iris Litt and Dr. Cohen, Montefiore Hospital Adolescent Service, July 6, 1973.

Today's specialists often do not. When "family doctors" were available, they would treat a person from cradle to grave, drawing on their personal knowledge of a family to help effectively, and often had the trust of the teenage family members. With the diminishing number of these general practitioners, at least in urban centers, the situation has changed. Pediatricians see children up to a given age, usually 13 or 14, and then stop. The family tends to go to an internal medicine specialist for check-ups, or to other specialists, and the child, when he reaches the pediatricians' cut-off age, is dealt with as an adult. Likewise, hospital clinics are set up the same way: a pediatric clinic, then a medical clinic and specialty clinics.

There is as yet no cadre of doctors trained in adolescent medicine in this country. In New York State there is not one publicly-funded training program. There are a few privately-funded ones.

Nationally, there are four federally-funded slots for training physicians, and 21 privately-funded ones.*

Commission staff met with Iris Litt, M.D., and her associate, Dr. Cohen, at Montefior Hospital Adolescent Service.

Drs. Litt and Cohen view an adolescent medicine service as an excellent door to intervene in the teenage patient's life-style, where necessary; and thereby to prevent drug abuse or ending drug experimentation, in addition to other social and medical problems.

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*Ibid.

They see Adolescent Medicine as the best way of reaching teenagers because physicians have not yet used up their "credit cards" with young people. Many of the other "helping" professions have. Montefiore did a survey recently in which they asked 16-25 year olds to whom they would go if they were in trouble (teacher, parent, peer, minister, doctor, social worker, et al). "Doctor" rated very high on the list.

Montefiore's Adolescent Medicine Division is geared to the "total person" approach to medicine. They find their young patients come to them only when they are in real pain or discomfort. Once there, and having received physical relief, they are open to discussions of other problems, and are referred to social service for a great deal of direct help and for referral to other agencies, with follow-up.

Often, the presenting problem turns out to be not the most basic problem. For whatever reason a patient is referred, once there, other problems are discovered and treated. For example, a patient referred by his family for marihuana smoking, which they considered to be the presenting symptom, was found to be psychotic and treated for that.

Another patient, referred for other symptoms, may be found to have a drug problem, and this is dealt with along with the rest of his medical problems.

One example of the kinds of social help offered by the service is as follows:

A child who has dropped out of one high school but would like to go to another one, perhaps with a specially-tailored program, would never think of approaching the school himself. Social services will arrange for this sort of thing.

Drs. Litt and Cohen outlined the following problems they considered subject to legislative remedy:

1) There is no central agency responsible for adolescent medicine. In the City Department of Health, statistics on teenagers are lumped in with Maternal and Child Care. It is impossible to get data on this group from insurance companies, because they are always covered under a family plan, with no specific age differentiation.

There should be a central agency to collect and hold data on medical problems of adolescents and also to be the responsible body to whom medical practitioners can bring their problems.

2) Legislative provision for an adolescent to receive medical care without parental permission, in certain instances, has not accomplished its purpose, because the teenager cannot pay for his care without going to his parents. It should be possible to provide each under-age member of a family with his own medicaid card, or private insurance card, since he is covered anyway under the family plan.

3) Training programs for physicians must be funded.

II. The Astor Home:

One voluntary agency which succeeded, where Montefiore Hospital failed, in establishing a connection with the Board of Education, is the Astor Home. The funding for their project was initiated by private foundation, although eventually state reimbursement for service will be available.* About one year ago, Astor Home, which operates residential treatment centers for children, some of whom attend local public schools, offered a service to P .S. 21, in the Bronx, as a pilot project to identify mental health needs of that area. They offer skilled and trained consultation to the teachers in that school in how to cope with and help students who are presenting problems. It quickly became clear that some of these pupils and their families should be referred to a child guidance clinic. There being none available in the Northeast Bronx, Astor Home developed one. They have been offering child guidance counseling to everyone who applied for it, and because they are so new and unknown as yet, they do not yet have a waiting list. It is their hope to obtain sufficient staff to continue to avoid such a list. They have been in the process of obtaining state certification since October, 1973, most of the problems they encountered being centered on the physical plant of their clinic. Required renovations were completed in January, 1974. They have involved Misericordia Hospital Adult Psychiatric Service to cooperate in the consultation service offered the teachers at P.S. 21, and Misericordia accepts the adult members of the family of any pupil who requires their service.

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*Interview with Sister Anne, Director, Astor Home, Feb. 25, 1974

Additionally, they have enlisted the cooperation of the pediatric service of Misericordia Hospital, to provide the health care the children need.

Sister Anne, Director of Astor Home, expects to draw in the Visiting Nurse Service, to provide health care at home, and follow-up care, where needed. She indicated there was urgent need for staff intervention to help many of the families find suitable housing, because their living conditions were exacerbating problems, or because they were in a housing crisis, such as eviction. They do not have sufficient staff to provide this service, but she considered it probably inevitable that they eventually do so.

They are also expanding their teacher consultation service to three parochial schools in the neighborhood, in the hope of also being of service to those families whose problems are not necessarily financial but who still cannot afford expensive private professional services.

COMPREHENSIVE HEALTH CARE

The Partnership for Health Law, passed by Congress in 1970, calls for the development of Comprehensive Health Planning

Agencies in each state, and the development of Health Maintenance Organizations. Edward H. Van Ness, Executive Director of the New York State Health Planning Commission, described a Health Maintenance Organization as "any program for delivery of health care with the exception of solo practice on a fee-for-service basis. Essentially, in an HMO, the emphasis is on preventive medicine." He continued:

> "An HMO is a pre-paid health care system that provides its members with periodic screening and a check-up to detect disorders before they make people sick. All of us have found that it costs a lot less to keep a person well, than it costs to make him well after he's become ill. An HMO provides or arranges for all ambulatory or in-patient health care services, and assures effective continuity of care. There are HMO's of various kinds already operating throughout the country."*

New York City's Health Insurance Program is one such Health Maintenance Organization.

In 1970, New York City's Office of the Mayor established the Mayor's Organizational Task Force, which eventually became the Comprehensive Health Planning Agency of the City of New York. That Agency, in its grant application of March 31, 1971, describes its goals as follows:

> "Our priorities are in terms of the individual and his family rather than disease categories. They derive from broad-based problems, whose solutions will affect changes in health delivery.
>
> "The goal of the work program is the development, in the community, of an integrated system of planning for environ-

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*Van Ness, Edward H., Executive Director, New York State Health Planning Commission, in an interview published in Health Planning, op. cit. March/April 1971.

mental and personal health care which will have the following components:

1. Establishment of CHP Districts and District Boards so that the various communities of our city can participate in comprehensive health planning.

2. An environmental setting (including land-use, safe and adequate housing and transportation, clean air and clean water) within which our citizens can enjoy life.

3. A process whereby individuals and families entering the health care system can relate to a primary physician or health professional who is a member of a health team. The health team will provide basic preventive, diagnostic, therapeutic, and rehabilitative care. The health team will also coordinate and supervise appropriate referrals to other health-related specialty services for both ambulatory and in-patient care.

4. A system for the collection of health data.

5. Neighborhood health centers, institutional-based out-patient departments, and group and solo practitioners of medicine which will be incorporated into the system and included in a coordinated network of communication.

6. Health services which will be available, on the same high quality basis, to individuals of every socio-economic level. The individual can choose for himself the type of entry into the system he prefers: neighborhood health center, a community based group health practice, an institutional based group, or a solo practitioner.

7. Mental health and mental retardation services, school health services, home health services, and environmental health services which will become part of the coordinated system, so that separate programs for diagnosis of lead poisoning, rubella immunization, or establishment of methadone clinics will be unnecessary.

8. Examination of methods of financing medical and dental care so that the Agency - to the extent it has power or influence to do so - can ensure that every individual, with his family, is protected against illness, and is covered for ambulatory, inpatient, and home health services. This will include basic medical care in all the major areas, as well as ancillary services such as nursing and social service. The Agency will also examine the financing of environmental health services, and will make recommendations upon this subject.

> 9. Regular dissemination of information about planning for environmental and personal health services, which will be an important component of all the work programs.
>
> 10. Training of consumers and providers in methods of comprehensive health planning and program content of the work programs, which will be a continuing responsibility of the Agency.
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> "The Agency will attempt to build into the system ongoing evaluation of the quality of medical care provided, of satisfaction with personal and environmental health services, and of appropriate and effective utilization of professional personnel. It will also attempt to develop a plan for ongoing evaluation of environmental health."*

Their statement on continuity of health care deserves special attention.

> "Ambulatory care includes office services of private practitioners of medicine and dentistry, hospital-based outpatient clinics and emergency rooms, neighborhood health centers, union health centers, and pre-payment group health programs. Ambulatory health services are frequently crisis-oriented, discontinuous and non-comprehensive. Patient amenities are frequently disregarded; records of previous visits are not available; and the patient may be seen by a different physician, nurse or social worker at each visit. In a well-organized system of health care, every individual should relate to a health professional who has access to the individual's past history and who can develop a personal relationship with him.
>
> "The point of entry into the health care system should be contact with a physician who will perform a complete medical evaluation of the individual with appropriate diagnostic procedures.
>
> "Ongoing surveillance and maintenance of a personal relationship with the individual and his family may be delegated to the health professionals other than the physician; e.g., a health team, a nurse clinician, a patient advocate and other professionals and para-professionals. This method of delivery of health care functions well if a physician is readily available for consultation and if the health professional or

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*Grant application, Comprehensive Health Planning Agency of the City of New York, Vol. II, March 31, 1971, pp. D-2 and D-3.

para-professional has been taught when to call for the medical expert. The utilization of nurse clinicians for routine well baby care in Denver, the ongoing care of cardiac patients by well-trained physician's assistants, has been described.

"As a part of the study of the delivery of ambulatory care, we might investigate reasons for the lack of continuity of patient care in our existing facilities and develop a system which will ensure every individual and family a personal physician at the point of entry into the health delivery systems with surveillance by a physician or health professional assigned to the patient with whom the patient can arrange an appointment for each successive visit. Assurance of continuity of medical care for the individual patient is the critical factor in the delivery of high quality medical care. Continuity of care means assumption of responsibility by a physician or health professional to whom the patient relates. This method will ensure the following:

1. Knowledge of past episodes of illness, previous diagnostic procedures and therapy;
2. Adequate history, physical examination and medical evaluation;
3. Availability of appropriate diagnostic tests and evaluation of the results;
4. Institution of immediate treatment and a plan of care;
5. Referral to appropriate medical, nursing and social agencies;
6. Maintenance of preventive health care;
7. Care of concomitant socio-economic and emotional problems.

"This type of care can only be given when a single health professional or a health team maintains an ongoing personal relationship with the individual patient. This can be done in a variety of ways, provided there is immediate availability of a physician when necessary.

"In order to achieve this goal, an ambulatory care facility must have the following organizational structure:

1. an appointment system;

2. full-time or part-time professional staff rather than a rotation system; e.g., physicians and nurses who rotate through outpatient department at 3-month intervals;

3. a unit record system, in which laboratory and X-ray reports are readily accessible and available;

4. an adequate number of general medical, pediatric and dental clinics in operation at hours convenient to the patients and which provide diagnostic, therapeutic and preventive care;

5. availability of appropriate back-up specialty services and diagnostic facilities;

6. 24-hour telephone service manned by a health professional so that advice and reassurance can be given and immediate decisions made.

"The concept of the 'open hospital,' for both municipal and voluntary hospitals - that is a hospital in which every physician, licensed by New York State, can admit and treat patients, should be investigated.

"Quality of medical care can be maintained in an 'open hospital' by public regulation of surgical and specialized medical procedures for physicians qualified in the specialty and by stringent regulations about medical consultations; e.g., an infant cannot be discharged from the nursery without a complete examination by a pediatrician. An 'open hospital' provides continuity of care for the patient and can be a factor in doing away with the double standard of medical care - patients admitted to a ward service who do not have a personal physician and are cared for by the 'house staff' under supervision of the attending on service.

"Increased emphasis should be placed on encouraging generalists in community medicine practice, and teaching in medical schools and hospital programs which emphasizes the concept that the primary purpose of medicine is patient care and that medicine is a service profession."*

On the state level, a bill introduced by the Standing Committee on Health of the Assembly, which has acknowledged the need for prepaid comprehensive health services plans, stated the legislative intent of encouraging the expansion of health care options, and provided for state certification of such services in a proposed law. The bill* introduced would supplant Article 44 of the Public Health Law, which provides for the creation of non-profit medical corporations, and would provide instead for the operation of comprehensive health service plans.

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*Ibid, attachment 8-1 and 8-2.

The bill defines a comprehensive health service plan as a "plan in which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance or periodic charge."

It defines comprehensive health services as "all those health services which an enrolled population, defined as to its probable age, sex and family composition, might require in order to be maintained in good health, and shall include, at least, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, home health services and preventive emergency and health services. Such term may be further defined by such regulations as the commissioner shall deem necessary, desirable or appropriate to meet the health care needs of a population."

The bill contains the following statement of policy and purposes:

> "§4400. Statement of policy and purposes. Improving the present method of delivering health care services is a

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*Assembly intro. #9232, introduced by Mr. Hardt, Feb. 4, 1974, pp. 2 and 3.

> matter of vital state concern. Without improving the present system, increased health insurance and other benefits will continue to escalate the cost of medical care and overload the delivery system. Prepaid comprehensive health care plans, wherein members of an enrolled population are each entitled to receive comprehensive health services for an advance or periodic charge, represent promising systems for delivering a full range of health care services at a reasonable cost.
>
> "Accordingly, it shall be the policy of this state to expand the health care options available to the consumer and insure that he will have freedom of choice in choosing that plan which is most compatible with his needs."

The urgent need to reform health services delivery is reflected in the fact that Congress is currently considering six major legislative proposals for health care. These include the Kennedy-Griffiths-Corman bill, entitled "The Health Security Act", a single-track program which would provide a Health Security Trust Fund, of monies from general taxation and from additional social security taxes; the Long-Ribicoff proposal, entitled "Catastrophic Health Insurance and Medical Assistance Reform Act of 1973", which purports to provide catastrophic insurance for virtually every American, an extended medicaid type coverage for low income families, and "a new and voluntary federal certification program for private health insurance policies", based on the assumption that if the government accepts responsibility for the highest risks, in the first two parts, "the voluntary insurance industry could reasonably be expected to meet the challenge of adequate basic health insurance for the remainder of the population."* A third major proposal is the Administration Plan for National Health Insurance, also a two-track program, with a Standard Employer Plan, which would require private employers to offer to their employees a minimum package of benefits and pay 75% of the premium cost, and a Government Assurance Program, to replace Medicaid, under which private health insurance carriers would contract to cover low income persons, using federal funds to cover or subsidize costs, and cost-sharing by the insuree dependent on income.

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*Fulton, Tom, ACSW, "Federal Legislative Proposals for Health Care," The Advocate for Human Services, published by the National Association of Social Workers, Washington, D.C., Vol. 2, No. 23, December 15, 1973 and Volume 2, No 24, December 31, 1973.

Whatever plans are eventually accepted, this Commission recommends that health and mental health services be made available in residential communities of all income-level housing, in one building or a contiguous complex, and that these services guarantee continuity of care, with adequate and vigorous follow-up to ensure that medical recommendations are understood and accepted by the patient and his family.

We recommend that services be organized in such a way that they serve the needs of people, rather than those of medical specialties, or administrators, or other considerations.

We further recommend that health and mental health facilities, both public and private, be available to all schools, either as offered by Montefiore Hospital's Adolescent Service, or through back-up services and consultation, as in the Astor Home-Misericordia Hospital Model. Schools, after all, are the one agency through which every one of our children passes.

CHAPTER V

THE FAMILY

Children live in families and families live in communities. Therefore, if we are to provide that gamut of options we consider to be genuine drug abuse prevention, we must look to the setting from which most children receive, or fail to receive, succor.

Many of the professionals who responded to the Commission letter of inquiry regarding their views on prevention of drug abuse stressed family breakdown, and value vacuum, as causations of drug abuse.

THE FAMILY AND DRUG ABUSE PREVENTION

Of the need for nurturing, Ruth Sullivan, ACSW, Casework Supervisor, Family and Children's Service of Albany, wrote to the Commission, dated October 9, 1973, "...based on my many years of experience of counseling with people - of many age levels, varieties of economic and social achievements, racial and ethnic backgrounds, and a wide range of personality deficits - I am brought again and again to the significance of the quality of emotional nurturing, so often lacking (in one degree of another) in people's childhood experiences. Also, so much of people's current behavior (constructive and destructive) has the underlying motivation of remastering or undoing earlier deprivation and/or unfulfilled longings. The regressive symptoms and effects, resulting from drugs and alcohol dependence, are another indication of this same infantile struggle.

"Mainly, I wish I knew of some effective way of helping people to be more comfortable with their conflicting feelings and fears - to help them realize we all experience the same emotional tensions and pressures, at one time or another and with varying degrees of intensity. Education and group discussions at critical stages; marriage, pregnancies, school years, adolescence,need to be implemented..."

Norman A. Cosentino, Head Counselor, Educational Society for the Prevention of Adolescent Drug Abuse (ESPADA), wrote, August 15th, "Most drug related problems come about due to family instability. The person then adjusts his lifestyle to compensate for the lack of affection attention and the great amount of pain he feels. It is this 'negative' lifestyle that can lead the individual to drug abuse."

Thomas A. DeStefano, Director, Catholic Charities, Diocese of Brooklyn, put it this way, (August 29, 1973) "While we have found training for staff with regard to drugs is important, we feel the more successful approaches are two-fold:

1. Humanizing the youths' immediate reality - whether that be foster care or family.

2. Creating meaningful options in the lives of youth."

And Louis A. Patrizio, M.D., Commissioner of Mental Health, Oneida County, wrote on September 10, 1973:

"First of all, family breakdown and dysfunction are in part responsible. If a child is raised in a home environment that leads him to believe that he is loved, accepted, and has value in himself, then there is a strong possibility that he will not turn to drugs.

Conversely, if his family does not know how to reasonably solve its internal and external problems, if it scapegoats the child, leaves him with feelings of worthlessness, then he may turn to drugs as an escape, to relieve anxiety or to gain acceptance from peers.

"With regard to the societal component, I believe that many families that are poorly equipped psychologically, often succumb more easily to economic pressures. For example, if the head of a household suddenly becomes unemployed and is unable to find a comparable job, then undue stress may be placed on the family and give rise to internal conflicts.

"Lastly, it is the responsibility of the society to provide services to families to prevent breakdown or restore harmony."

Irving Rabinow, Associate Executive Director, Jewish Child Care Association of New York, added the thought, in his letter of August 22, 1973: "There is a need for comprehensive supportive services to families of these (disadvantaged) children to avoid family disintegration, meaningful employment for adults which adds to parents' sense of self-worth, and educational and vocational training opportunities for youth...The latter is particularly important because the highest incidences of drug abuse and drug dependency is among the 16-18 group...These preventive goals seem to be within the possibility of achievement if our society is willing to provide the leadership and funding for such programs."

THE EMBATTLED FAMILY

It is relevant to review some of the conditions which place stress on the urban and suburban families in which children live - those children who abuse drugs and those who do not—and to evaluate how our present system of societal support for these families succeeds.

If we want to cure those who are abusing drugs, and to prevent those who have not begun to turn to drugs from doing so, it is time to care about drug users and non-users: to care about children and about the families and communities they need if they are to have a means of coping and of enjoying that is not chemically induced. To cure stems from the Latin curare which means to care.

New York State, like the rest of the nation, has characteristics which are unique and which affect the ways in which families function and children feel they "belong" or do not, they can achieve, or cannot, they are worthwhile, or are not.

These include the rich diversity of our population, but also the extent to which our population is organized, geographically and socially, into distinct ethnic groupings, each of which feels strange, and estranged from the others. This estrangement leads to fear, and to tension, and diverts the members of a community from identifying the source of their neighborhoods' problems and working cooperatively to solve them.

Another characteristic which shapes the milieu in which New York children grow is our tradition of upward mobility, which stresses creativity and individual achievement, rather than teamwork. The Horatio Alger tradition, when counterposed against the reality of slum life, is confusing. Supposedly, everyone who can "cut the mustard" can be a success. This philosophy is a spur to those gifted children from well functioning families who work together to help the child move up the ladder. But for most slum children, the way up is so booby-trapped by poor schooling and family stress that the legend serves only to highlight what seems to them hypocrisy, or it is realized through the channel of organized crime.

Geographic mobility, encouraged by the pattern of the worker following his job and the executive being transferred, and by the fact that housing is allowed to deteriorate, so that many are forced to forever "move on", makes it more difficult to engender that sense of neighborliness which helps sustain a family.

The absence of an extended family, to support the nuclear family (parents and children) makes social problems of situations which used to be coped with by the family in the course of daily living. A mother taken ill in the middle of the night, who has an aunt or cousin down the road or down the block to come over and care for sleeping children while she and her husband go to the hospital, has a medical problem, but not a social upheaval. Such a mother, without the closeness of relatives, but with roots in her neighborhood, can at least make do with friends or neighbors. But what of the family new to the community, isolated, or in a neighborhood where families live in such overcrowded conditions that there is no room next door to carry in sleeping children and put them to bed until morning.

The stresses such an isolated family feels are magnified when both parents are working or when there is a single parent. There are in New York, as of the 1970 census, 508,474 such families.* The stresses are further compounded when the family lives in poverty.

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*U.S. Census, 1970.

THE FAMILY AND POVERTY

In its March, 1968 report, the Joint Legislative Committee on Child Care Needs wrote:

"To not have enough money creates pressures which shatter a family, demoralize and debilitate a parent, trap a child so that when he reaches adulthood he is able only to perpetuate the cycle....

"Families disintegrate from the sheer stress of trying to support themselves on an income that cannot cover their basic needs."

The 1970 census reported 17.3% of the 2,044,000 families with children in New York City had a single head of household who was female, or 354,000 families. Among Blacks, the figure rose to 32.8%.

The 1968 committee report explained the high percentage of broken families in Black ghettos as follows:

"When families come to New York together from rural areas, the very pressures of urban living cause disintegration of family structure. Here the family does not work together in the fields, the father does not come home for lunch, the children are not an economic asset. When, as happens too often, the mother finds work and the father does not, the process of his developing a sense of uselessness and worthlessness, culminating in his inability to face the situation and flight from it, begins..."

The report cites testimony before the Senate, in July, 1967, that only two out of five adult men in the Black ghettos of New York City earn at least $60 a week, and fewer than three out of five hold any job.*

"All the problems of the central city fall in upon the mother-and-children family with special impact," the report continues. "The concentration of low income population in the inner city, the fact that such a small amount of housing has been built in thirty years, the overcrowding of our schools, the shortage of jobs for unskilled workers, the scarcity of health services, the breakdown of public services such as environmental sanitation and police protection, the absence of an organized extended family such as aunts and uncles, grandparents, in a position to babysit, to help with finances, to share household chores, make the lives of these women extremely pressured...

"Because of the low level of public welfare budgets, the option to be a homemaker and raise one's children oneself, with the help of public welfare, is not a real one. Being a homemaker implies managing a budget, making choices and decisions about spending which involves one's value system and what one wants for one's children, expressing one's concepts of 'homeyness.' The current welfare payment level allows for none of this. When the money coming in covers the bare minimal essentials needed to maintain life, without a radio or TV, without a telephone, without extra carfare or movie money or money for curtains, there is no room for options. There is no homemaking..."

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*A comprehensive Blueprint for Child Welfare Services in New York State, Report of the Joint Legislative Committee on Child Care Needs, March, 1968 (Legislative document 1968, No. 8) p. 51.

"If we are to enable today's children of poverty to become part of the mainstream of American life and to become adults who contribute to that life, we must take a dual approach which gives today's mothers a genuine option. We must make it possible for those who wish to, to remain at home to really be homemakers, and we must make provisions for those who prefer to support their children by their own labor to do so while their children receive good care."

THE MIDDLE CLASS FAMILY

Families with a middle or upper class income and life-style are now living through their own crises of goals, directions, values. The old ones seem no longer to work. The children are searching for new ones. The parents are often lost. This crisis seems connected to the broadest social issues, such as the role of this nation in international affairs and the moral leadership the U.S. used to exert and seems to have lost; to the affluence and technology which have made homemaking dependent as ever on the skill and art, the sensitivity, perciptivity and tenderness of the homemaker, but no longer on her full time effort; to the emphasis on "finding oneself" which is the counter to the alienation and automatism imposed by the bigness of our social organizations. Against this backdrop, the middle class family is floundering, and feels unable to cope with the problems of their children, and therefore frightened to acknowledge that problems exist. This fright is often expressed as "permissiveness," as "wanting Johnny to know I trust him," summed up in the phrase, used for 13 and 14-

year-olds, "she knows the options and the consequences, now the choice is hers." That family members need to protect each other, that a child need not really live through all the pains of life personally, to "choose his way," is lost sight of. The mother of a 14-year-old girl, the bookshelves of the home she shares with her husband replete with the latest sociological treatises, explains she had just allowed her daughter to leave the home ostensibly for a school dance, and had agreed to a curfew later than she felt was justified by attendance at a dance, although she had an uneasy feeling that there was no dance that night, because "I want to be permissive." Why? "Because I am afraid if I am not, she will run away." This, too, is poverty.

Later, when the little girl returned, anxious and defiant after having spent the evening in the home of two 19-year-old young men, the parents did not want to know what she may have been through. They not only accepted her story ("It turned out there was no school dance tonight so we went to the movies"), but helped her lie ("maybe you tried to call us, but the line was busy"). To the child, this not wanting to know feels like not caring. It is neglect - neglect born of fear, of a sense of emptiness, of having nothing of value to give to and to hold one's child. That this child was already using alcohol and marihuana, with the parents' knowledge, and quite possibly other drugs, is almost inevitable. But it is also not the main point. The main point is the pain.

School will try to help, for the child is in trouble with herself there too. But the family has already dealt with that once by deciding the problem was that the school was too permissive, and sending her to a different private school. This mother does not work. She thinks it important, she says, to be home to "keep track of" her daughter. But even when she is there, she is not really there.* The best hope for this child is to come to the attention of someone who can know her confusion and help her. Our priorities being what they are, this is most likely to happen only when she gets into big trouble.

SERVICES TO STRENGTHEN FAMILIES

What, then, can be done?

With all of our declarations of belief in the critical importance of family in the development of a child, our society does not take family life as a value on which it is valid to spend money. Programs are never funded simply because they are good for the family. We require a secondary social goal that bears no relation to the goal of strengthening families so they can help their children to flourish. In so doing, we often miss the mark.

For instance, the goal of providing good care for children of working mothers, so popular in 1967-68, became distorted into that of getting mothers off welfare, which, in turn, meant that day care became a service to the poor, and, therefore, a poor service.

Little has changed since the report six years ago of the Joint Legislative Committee on Child Care needs. Our funding is still concentrated on those most expensive, least effective,

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*Conversations with the family, January 1974.

"after the horse is stolen" programs, which are used to prevent personal problems from becoming social nuisances, rather than on services which could strengthen families and help them cope.

Day Care:

One preventive service is quality day care, to nurture the children of parents who work or those of mothers who need some relief from 24-hour child-caring. Without diminishing the value of a close parent-child relationship, it is conceivable that in many situations the mother who, unwillingly, is with her child full time, is harassed, angry, ungiving, and that the temporary care for her child outside the home (that surcease once, but often no longer, available through the cooperation of cousins, aunts, and grandparents), would vastly improve the quality of such closeness. Similarly, the working mother whose mind is at ease about her child's care can return in the evening much better able to cope with the problems left over from the day than can the one who is tense and guilty and anxious about her child's care, and then must cope with a frazzled, possibly mistreated child.

Katherine Oettinger, former chief of the U.S. Children's Bureau, estimated in 1968 that nationwide, 38,000 children under 6 were left with no care at all while their mothers work. Many were just locked up at home. Another 70,000 were cared for by sisters and brothers often not much older than themselves. That year, a study by the Medical and Health Research Association of New York found children cared for in appalling conditions and mothers pleading for the creation of proper facilities for their children.

The 1970 census counted, in New York State, 219,074 married women with children under 6 years who worked outside the home; 128,838 women Heads of Household with children under 6 and another 100,636 with children 6 to 18 years; and 60,000 male Heads of Household with children under 18. These are the families, by and large, from whence come the latchkey children, who spend the hours between the end of school and the parent's homecoming unsupervised, often aimless and lonely, the preschoolers left with neighbors and unlicensed day care homes who are sometimes neglectful, sometimes even cruel. These are the families in which the 11 year old must stay home from school if the 4 year old is sick and cannot go to the caretaker down the block and the parent must work.

The Agency for Child Development, in New York City, estimates there are in the city 250,000 children under age 6 whose parent(s) are on welfare or whose mothers work and the family income is under $10,000 per year. The Agency considers all these children to be among those who would greatly benefit from skilled day care. But there are in the city 47,000 day care slots for such children. Although this is substantially above the 7,000 such slots available in 1968, it is still, according to Georgia McMurray, only 10% of the minimum needed.*

And what about those families earning more than $10,000? What are their options? Again, there is the neighbor down the block -

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*Interview with Georgia McMurray, Commissioner, Feb. 18, 1974.

and there are paid babysitters who will come to the child's home. But any working parent can attest to the mixed bag from which such assistance comes, the disruption in a child's life when the caretaker is replaced, the absence of playmates and loneliness of such children.

Day care, as originally conceived, was intended as a service to all children, regardless of income, who would benefit from an alternative to a parent's care at home.

With the first flush of enthusiasm and early federal funding, in 1967-68, many day care centers were set up to take children of all economic levels in the neighborhood, on a sliding scale fee basis.* This enabled children to mingle in a socio-economic mix, and it enabled daycare centers to supplement services they could buy with government funds. By 1972-73, official policy was moving toward tighter restrictions on who was eligible for day care, a sharp limitation on the number of fee paying participants, and a cutting off, in essence, of all those earning over $10,000 by pricing day care out of the market ($70-$80 per week per child) for those not eligible for partial reimbursement.

Because of the $1.9 million ceiling on Federal spending under Title IV A, the Agency for Child Development will receive only 50 percent Federal reimbursement for fiscal year 1973-74. Unless the ceiling is raised, the percentage of Federal money will be even lower in 1975-75.

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*The Westside Center, for example.

This means less day care for the poor, and much less day care for the children of middle class parents.

Homemakers:

Another such family-strengthening service is homemaker service, that service whereby a homemaker stays in the home, substituting for the mother, during a temporary emergency, holding the family together, instead of the children being placed in foster care, often separated from each other.

Studies have shown that where a homemaker has gone into a home and kept the children together, the parent, temporarily disabled, has recovered more quickly, has resumed the care of the children, and moved toward independence.

Where the children are placed outside the home during a crisis, the family disintegrates and the parents tend to deteriorate and to fail to resume the care of the children.

The U.S. Department of Health, Education and Welfare estimates that New York State needs 18,800 homemakers.* In 1966 there were 957. Lacking an infusion of Federal funds, the service has grown slowly.

The New York City Department of Social Services, in a pilot project in 1967, maintained 2400 children in their own homes who would otherwise have been placed, by sending homemakers to them. In most situations the homemaker cared for the children on a short term basis, during a crisis period. This gave the family time to make long term arrangements, if necessary. This small New York City experiment saved the state close to $80.000.

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*Are Services To New York's Children Effective? Report of the Joint Legislative Committee on Child Care Needs, 1966, p. 20.

The cost of homemaker service today ranges from $1.85 to $7.50 per hour,* depending on the number of children, the city in which the service is offered, and whether the homemaker sleeps in or not.

Without these services, all too often the children who would benefit from them are placed in institutions, or in one of the alternatives to large settings: agency-operated boarding homes (with a capacity for up to six children), group homes (7 to 12) and group residences (13 to 25). There are 28,000 New York City children in such placement, both public and voluntary agency sponsored, at an annual public expense of $170 million.** Foster care, the least costly, runs to $4,015 per child per year, and group homes, $12,000, and institutions $14,000. What might have been done with a fraction of that amount, spent early, before the situation deteriorated to where placement was necessary?

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* Information from Herbert Alfasso, New York State Department of Social Services, February 1974.

** Report of the City Planning Commission, cited in New York Post, Feb. 13, 1974, p. 32.

Some agencies are trying to service children and families in the neighborhood. The Wyltwick School for Boys, for instance, operates a community-based family services center in Brooklyn, which works with other agencies in the 79th precinct to coordinate services and to identify gaps in service, and operates an adolescent program of education and vocational help and a day care center for 10 to 14 year olds who either come after school or, if they are school dropouts, who stay all day and receive Board of Education accredited courses. In addition, this center trained 12 women from the neighborhood as homemakers. These women go into the homes of families who are disorganized or are in a crisis situation, instead of the children being placed, and help the family negotiate with department of social services, help them relocate, intervene with the schools, and otherwise ameliorate tensions and help the family hold itself together. The service has been functioning for over a year.

The homemakers are on an annual salary of about $8000. The human benefit derived from a service which helps a family stay together and learn to function more cohesively is matched by the fiscal savings of this service in contrast to the cost of placement. Funding, however, is chronically insecure.*

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*Interview, Wiltwyck School for Boys, Inc., Feb. 20, 1974. Jacqueline Pitt.

Self-Help Efforts:

A number of self-help modalities are being developed. The Visiting Mothers-Sereno Workshop on New York City's lower Each side, is one such. The mothers on one block formed themselves into a cooperative day-care and extended family service. Linda Cusmanno, a founding member, explained, "Sometimes a mother just falls apart - especially after her welfare worker has visited. She just can't function. We go in and take her children to our house, or stay in hers and call a doctor if she needs one, or just let her rest."* A simple formula. A service many of us take for granted. But most of the mothers living alone with their children in poverty in New York have neither the ingenuity or energy to sustain such an endeavor.

Cooperative living arrangements, in which several families share a large apartment and help each other, substituting for the extended families which they do not have, is another type of self-help. The efforts of the young, themselves, to build their own substitute families, by establishing cooperative living arrangements, or communes, is another.

Employment:

The simplest alternative to drug abuse is a job which is at least moderately satisfying and which pays a wage on which one can afford the basics one considers essential.

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* Testimony, hearing, Joint Legislative Committee on Child Care Needs, Dec. 14, 1967.

This is true for the teenager and young adult seeking employment. It is also true for the head of household seeking to provide his children with a stable home.

This Commission pointed out, in a report in January, 1973,* the counterproductivity of "spending millions of dollars on treatment with the result that millions more must be spent to keep able-bodied young people on welfare" for lack of jobs. Again, in a March, 1973 Report,** the Commission noted that "The inability to become self-supporting, frustrating the ex-addict's drive to become socially constructive, can nullify the rehabilitation process."

But the employment problems of addicts are overlaid on employment problems of a broader group. Although rehabilitated addicts do suffer special discrimination in employment, a lot of other people cannot find work either.

The U.S. 1970 census counted 6,470,450 male population over 16 in New York State, of which 4,579,774 are potentially in the labor force. It counted 6,963,022 females over 16 in New York State, of which 2,878,973 are potentially in the labor force.

It defines "not in the labor force" as "students, housewives, prisoners, disabled, aged," and seasonal workers who are not job-seeking off-season. The census does not count, as unemployed, students, "housewives," disabled, and others who may be seeking work but are not registered anywhere as unemployed because they have never been employed. Nevertheless, based on their criteria, the unemployment rate is as follows, in New York State:

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*Employing the Rehabilitated Addict, supra.

**How People Overseas Deal with Drugs, supra.

Unemployment Rates

		Total	Black	Puerto Rican
MALES	16-19 years	10.9	20.8	17
	20-24 years	6.5	9.4	8.5
	All ages 16 & up	3.6	5.6	6.1
FEMALES	16-19 years	8.7	13.9	13.1
	20-24 years	4.8	6.9	7.5
	All ages 16 & up	4.6	5.2	7.8

Each person forced into the statistical category of unemployment is a human person - an eighteen year old young man with nothing to do but "hang around," a thirty-five year old woman forced onto welfare. The deadening monotony of unemployment is expressed in a popular recording by a comedy team call Cheech y Chong,* one sequence of which involves a school teacher asking a boy in class to read his essay on "How I Spent My Summer Vacation." He says: "The first day of my vacation I woke up. Then I went downtown to look for a job. Then I hung out in front of the drug store. The second day of my summer vacation, I woke up. I went downtown to look for a job. Then I hung out in front of the drug store. The third day of my summer vacation, I woke up..." Sales volume indicates this one hits home.

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*Cheech y Chong, Big Bambu, Ode Records, Inc., distributed by A & M Records, Inc., Beverly Hills, Calif., 1972. SP 77014.

The "make-work" jobs that characterized the Office of Economic Opportunity programs have done little to foster self-respect or contribution to the community. Yet there is real work which really needs to be done. There is need for schools, hospitals, libraries, parks, playgrounds, roads, community centers, day-care centers, after-school study centers, neighborhood health clinics. There is need for new railroad beds and tracks.

This Commission finds that one alternative to drug abuse is regular employment at work which is socially useful, and that to accomplish this may require job training, adult education, and day care for the children of the employed and of the student.

HOUSING:

One of the social needs of a family and an individual is, simply, a decent place to live. All other problems are compounded and intensified if they must be lived through in a cramped home, with inadequate heat or light or plumbing, and no corner in which to hide or to do homework or to be quiet. Light and room and air are essential to health and morale. The energy spent on, and the abrasiveness of, a constant battle against the draught of broken windows, against rats and roaches, against leaks and uncollected garbage, leaves little room for tolerance and understanding of each other, within a family, or for thinking things through and solving problems, for the individual. It costs too much to just survive.

And yet many people in the urban centers of New York State are left alone with this battle.

In New York State's large cities, 3.2% of housing units lack either plumbing, hot water, light, or other essential facilities. This is 195,000 housing units, or 195,000 families, of whom 145,000 live in Standard Metropolitan Statistical Area.*

Regarding overcrowding, the census definition is "more than one person to a room." There are, in New York's largest cities, 446,000 such units.

In 1965, a New York City study of unmarried mothers caring for their infants revealed that only 58% of the women with babies had a bathroom and a kitchen in their own apartment, throughout the period of the study, even though some moved several times.**

Since then, things have been getting worse. In 1968 (the most recent study available) the New York City Rand Corporation found that between 1960-1968, 180,000 housing units in that city had been lost by abandonment. The New York City Housing and Vacancy Survey of 1965-68 determined that during those four years, 107,000 units had been lost through abandonment. The rate is accelerating and, according to the Citizens' Housing and Planning Council, has continued to accelerate since then.

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*These statistics and those immediately following are from the 1970 U.S. Census of Housing, as reported by James Rowan, Citizens' Housing and Planning Council, Inc.

**Sauber, Mignon and Paneth, Janice, "Unmarried Mothers Who Keep Their Children: Research on Implications," Social Work Practice, 1965.

Have these units been replaced? In 1970, the number of residential housing units on which starts were made, throughout New York State, was 57,000. In 1971, the number of residential units finished in New York City was 19,000.* The net loss, per year, in New York City, is about 4000-5000 units.

Compounding the problem is the fact that most of the units lost are low-rent units. Most of the units built are moderate or high rent. Those who cannot afford the rentals in new buildings are either crowding more and more densely in cheap apartments or spilling into housing which was once adequate but became deteriorated to where the original residents fled and, rents being controlled, poorer people moved in.

One indication of the shortage of livable housing in New York City is that there are approximately 160,000 public housing applications on file with the New York City Housing Authority. It is estimated that 21%, or one fifth, of the city's elderly are living in housing unfit for human habitation.**

In addition to the overall shortage of housing units, there are the problems of poor design and of destruction of an old but viable, living neighborhood to replace it with a mammoth housing complex without services or commerce.

Oscar Newman, in Defensible Space,***, pinpoints certain design factors which affect the amount of crime which occurs in any given public housing project. These included: dead space versus traffic space (the more traffic, the safer); height of buildings (the higher towers had startlingly higher crime rates than low buildings); the number of apartments per floor (the fewer, the safer, because then everyone knew his neighbor, spotted strangers, and was more interested in what a stranger was doing there). Newman, like Jane Jacobs, also stresses the "natural surveillance" of busy streets, as a safety factor. In neighborhoods where the streets are lined with stores, and the stores are open evenings, and people use them, there is much less crime than in areas with large housing projects and no commercial space.

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* Report of New York City Planning Commission, 1972.

** Press Release, Citizens' Housing & Planning Council of New York, Inc., Jan. 21, 1974.

***Newman, Oscar, Defensible Space, Macmillan Co., New York, 1972.

In addition to the safety factor, there is the livability factor, the sense of community and of neighborliness engendered where there is mixed usage, that is, homes, shops, schools and theater, in contrast to a monolith of housing units alone.

According to the Citizens' Housing and Planning Council, the validity of Newman's findings, like the theories of Jane Jacobs, is generally acknowledged. Whether they will be utilized in future we do not know. There has been so little housing designed since publication of Newman's study that one cannot yet gauge the extent to which his findings have been acted upon.

It is clear that drug addicts and abusers need jobs and decent housing; that rehabilitated drug addicts and abusers need jobs and decent housing, so they do not have to cope with the stress of unemployment and poor housing and, in trying to cope, catapult back into the flight of drug abuse; people who are not on drugs but are "at risk" need jobs and decent housing for the same reason. Everyone needs "a room with a view," a door to close, and a friendly street to walk.

We are convinced that until we recognize and acknowledge that our families are in trouble, and that enabling them to work their way out of trouble is a top priority, we are in the position of the mother of the 14 year old girl who helped her lie rather than face the fact that the child needed her. We are not so poor, financially or ethically, but that, once we acknowledge the problem, we will have something to offer toward a solution.

CHAPTER VI

THE MEDIA

"(With regard to alcohol), except in special medical circumstances, the hazard is not in use, but in overindulgence. This is a danger inherent in virtually every human activity - eating ice cream, for example. To require advertisers to run cautionary notices against the misuse of products that are harmless when used properly (in this case, in moderation) seems to me to be against common sense."

Letter from the Publisher
of a Major Eastern Newspaper

ALCOHOL

The Commission to Evaluate the Drug Laws has taken the position, supported by most media research experts,* that basic attitudes toward substance abuse cannot be manipulated, but they can be reenforced. However, encouraging young people to use alcohol or drugs is much easier than discouraging such use, particularly because arousing an interest in the subject itself stimulates people to experiment. The arousal of interest in alcohol is a regular feature of all branches of the media. Although self-regulation on the part of television and radio precludes the airing of commercials for distilled spirits, beer and wine are freely advertised. Indeed, one of the most successful advertisements for beer encourages "more than one". The wine producers report phenomenal growth in sales since frequent television advertising was undertaken several years ago. Aimed specifically at the young, (Taylor Wines' "The Answer Grape", for example), commercials for wine have been considered a significant factor in the increase in sales of wine by 1,207,000 gallons (nationwide) from 1972 to 1973, or 12.4%. Although low alcohol-content wines enjoyed a certain popularity in 1972, by 1973 the principal increases were in the sale of table wines, from 3,504,000 gallons to 4,574,000 gallons.

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*See: Publications of the University of Connecticut Communication Research Program, Drug Abuse Information Research Project, Nos. 1, 8, and 9.

Despite current prohibitions on television commercials for distilled spirits, the licensed beverage industry has far from given up hope that they can penetrate to television. The president of one of the nation's largest distillers (Seagram)* stated:

> It doesn't look at this time as though we are going to break through into TV. However, the advantages in terms of speeding up to a tremendous degree our ability to communicate with the consumer would make it a very pursuable thing. Even if the door opens just a little bit, then we, as marketers of distilled spirits, should make every effort to use that particular medium. There is a lack of logic where wine and beer advertising is (sic) permitted on TV and radio and distilled spirits are not. Where do you draw the fine line?

As part of a campaign by the licensed beverage industry to stimulate sales among young consumers, 1973 saw an increase in television advertising for non-alcoholic cocktail mixes. This device may be designed to "open the door just a little bit" to hard liquor advertising, but even on their own, mixer and cocktail recipe ads encourage youngsters to experiment with alcohol.**

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*Quoted in the Executive Newsletter, August 31, 1973.

**Executive Newsletter, September 7, 1973.

We agree, in a sense, with the president of Seagram. We cannot see very much distinction in using a family medium, such as television, to merchandise wine and beer, if there is logic to the prohibition of advertising for distilled spirits. The vast increases in wine consumption in the United States by young people, and the experience of the French and Italians with their high incidence of wine-alcoholism leads us to conclude that broadcasters should take voluntary action to discontinue advertisements for wine and beer in the broadcast media, and, failing such voluntary action, the Federal Communications Commission should seriously evaluate the possibility of banning such messages by regulation.

In our chapter on the nature of the drug problems, we pointed out that there is nothing wrong with people's basic attitudes toward alcohol in our state and in the nation. However, the continual re-enforcement of the message that alcohol signifies pleasure and success may undercut the good judgment of many of our citizens, especially the young.* This is significant to us because of the proven ineffectuality of television messages attempting to instill caution with regard to drinking and driving.**

Moreover, a number of highly responsible witnesses have testified at our public hearings that permissive advertising of

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*Between 1965 and 1970, the 18-through-34 "youth market" had a numerical gain, for all alcoholic beverage sales, of 6.6 million. The 18-through-24's accounted for 3.9 million of the increase, the 25-through-34's only 2.7 million.

**K.E.Cook and W.E.Ferguson, "What Do Teenagers Really Think of Traffic Safety," TRAFFIC QUARTERLY, 22:237-243, (1968) alcohol bears directly upon the subject of all substance abuse, for two reasons: First, it promotes the concept that something ought to be available for a "high". Second, such advertising tends to impair the credibility of authority figures who perform regulatory, treatment and prevention functions with regard to drugs and alcohol, by sending out the double message that chemically induced joy is acceptable, providing the chemical is acceptable. Most Americans do not, in fact, believe that. Advertising may, however, persuade youngsters that most Americans hypocritically do believe in the truth of that message. This was the substance of testimony of representatives of the Suffolk County BOCES, of the Alcoholism Services of the Onandaga County Department of Mental Health, of the Long Island Council on Alcoholism and of the Rensselaer County Mental Health Board.

Not only is alcohol freely advertised on television in the form of wine and beer, and suggested in the form of mixers and cocktail constituents, it is also used as a subject of humor and general approval in the content of many programs. A survey by the University of Connecticut Communication Research Program demonstrated that from Monday to Sunday (excluding, by accident, Thursday night figures which then included The Dean Martin Show), there were 44 mentions or depictions of alcohol use on humor shows and 50 on serious shows. Only twice was alcohol refused. Alcohol tended to be depicted humorously 35 times, seriously 27 times, excitingly 8 times, favorably 30 times and unfavorably 18 times. The researcher evaluated the presentations as follows:

> alcohol is "fun"; it is social, has generally positive social (and often physical) consequences; it is often joked about and is generally spoken of and shown in a positive light; it is the most prevalent prime time drug.

Had The Dean Martin Show been included, we can only guess at the even further trend of the statistics. That singular NBC entry features repeated references to alcohol as virtually the only source of laughter or of any human relationship.

Alcohol has not always been as great a source of humor as it is today. Before the great national mistake known as Prohibition, alcohol was frequently treated as a subject of respect. The reasons were clearer in those days. The industrial revolution had brought great progress to our nation, but great suffering among workers. Ghetto life for the American working class in the 19th and early 20th centuries has only recently been proclaimed romantic by nostalgic historical revisionists. In fact, workers lived with disease, mental illness, violence and poverty. Alcoholism was rife, and few who witnessed the suicides and the insanity produced by alcohol prior to Prohibition could laugh about it.

Prohibition, itself, became the joke. The law was flouted and organized crime flourished as never before. Since that time, although the social costs of alcohol abuse have continued to rise, America has remained persuaded that the joke known as Prohibition still applies to all intemperate use of alcohol. In a way which would shock and offend all decent people if used in the context of heroin, alcohol humor abounds on television, despite the fact that, as a nation, we have at least twenty times as many alcoholics as we have heroin addicts. In the ghetto, alcohol has never been a joke, and is not one now. Dr. James Curtis, one of New York City's leading pediatric psychiatrists, has told the Commission staff that for fifteen years he has been witnessing the transition of inner-city youth to alcohol abuse from opiate and depressant abuse. As in the case of heroin, only when the problem spills across the boundaries of the neighborhoods of the poor, do the rest of us begin to lose our sense of humor about the subject.

Consistent with our duties and responsibilities under the First Amendment, we cannot go further than to make this statement with regard to television program content. We sincerely hope that the network executives and artists responsible for program content will avoid humorous depictions of alcoholic intemperance in the future.

Another concept advocated frequently by witnesses at our hearings who expressed concern about the advertising of alcoholic beverages was that a cautionary statement be included on all package labels and in all printed promotional literature, including advertisements and displays. According to these witnesses, the statement could be extremely simple: for example, "AVOID OVERINDULGENCE", "DRINK SENSIBLY" or "DON'T DRINK IF YOU'RE GOING TO DRIVE". The theory behind this proposal is not that it will discourage irresponsible drinking, although it might. The theory is that a contributory factor to drug use is a permissive attitude toward alcohol use. For more than three years, this Commission has received representations from young people who are seriously concerned about the hypocrisy of promoting alcohol use, on the one hand, and penalizing alternative drug use, on the other. The argument is not that children have a right to use drugs out of spite because their parents use alcohol. Rather, the argument is that children cannot fully believe that chemical substances may be harmful, when alcohol, the most abused chemical we know, is treated so positively in the majority of printed or visual representations which refer to its use.

The printed media and the licensed beverage industry appear to be in substantial agreement, as evidenced by the quotation at the start of this chapter, that because the Surgeon General has not determined that alcohol use may be injurious to one's health, no cautionary notice need be placed upon advertising accepted in the printed media. While it is, of course, true that overindulgence rather than sensible use of alcohol is the problem, as contrasted with any cigarette use, which is categorically harmful, the basic issue cannot be evaded: overindulgence in alcohol *is* a national problem, and those who equate such overindulgence with overeating ice-cream may be expressing a specious argument to disguise a quite substantial vested interest.

Advertising revenue in the printed media from alcoholic substances is extraordinarily high. One distiller listed an advertising budget of over $15 million for 1973, an increase of $5 million over 1972. The amounts spent nationally by liquor advertisers in newspapers in 1972 and the amounts spent in 1973 for space in magazines has been itemized and includes such sums as nearly $17 million in income to *Time* Magazine to over $1 million in *Psychology Today*. (See Figures 1 and 2.)

Figure 1.

Following is the amount spent by liquor advertisers in 1972 in newspapers on their brands as tabulated by Advertising Age:-

Afrikoko Liqueur	$ 15,097
Almaden Brandy	15,575
American Dist.(Multi-Products)	6,064
Ambassador Scotch	275,526
Ancient Age	274,009
Ancient Age (Multi-Products)	176
Ancient Ancient Age	88,898
Antique	130,877
Aristocrat Brandy	10,370
Aristocrat Gin	2,091
Aristocrat Vodka	905
Arrow Brandy	39,546
Arrow Cordials	8,925
Arrow Vodka	38,699
Asbach Brandy	53,904
Bacardi Corp. (Institutional)	529
Bacardi Rum	488,004
Ballantine's Scotch	299,117
Barclay's	51,794
Barton's QT	935,985
Beam	5,109
Beam's Choice	77,887
Beefeater Gin	240,543
Bellow's (Multi-Products)	90,833
Bell's Scotch	35,414
Bisquit Cognac	10,064
Black & White Scotch	367,870
Black Velvet	310,082
Blackberry Driver	159
Blackberry & Cherry Julep	1,206
Blackberry Julep	4,143
Bols Brandy	18,740
Bols Creme De Cacao	9,612
Bols Creme De Menthe	6,293
Bols La Creme De La Creme	6,393
Bols Peppermint Schnapps	2,026
Bols Sloe Gin	7,062
Bols Liqueurs	46,054
Bombay Gin	64,752
Bond & Lillard	17,441
Boord's Gin	6,234
Booths High & Dry Gin	190,514
Borzoi Vodka	33,078
Bourbon De Luxe	23,247
Burke & Barry	246,065
Cabin Still	54,885
Calvert Extra	1,027,193
Calvert Gin	77,200
Calvert Multi-Prods	$ 74,754
Campari Liqueur	73,222
Canada Dry	54,206
Canada Dry Bourbon	4,937
Canada Dry Gin	8,392
Canada Dry Vodka	818
Canada Dry (Multi-Products)	49,755
Canada House	33,256
Canadian Club	1,074,688
Canadian Deluxe	18,377
Canadian Lord Calvert	376,848
Canadian Ltd.	14,294
Canadian Mist	750,153
Canadian OFC	161,673
Canadian Reserve	12,001
Canadian Rich & Rare	226,756
Carib Cup Liqueur	50,899
Carrington	42,976
Carstairs White Seal	219,151
Cascade	55,952
Chapin & Gore	58,168
Cheri Suisse Liqueur	65,780
Cherry Heering Liqueur	12,933
Chivas Regal Scotch	334,630
Chivas Regal (Multi-Products)	421
Christian Bros. Brandy	67,156
Clan MacGregor Scotch	181,886
Club Cocktails	17,443
Cluny Scotch	43,137
Corby's Reserve	214,990
Coronet Brandy	160,065
Crawford Scotch	36,173
Cream of Kentucky	43,128
Crow Light	668,909
Crown Russe Vodka	85,535
Cutty Sark Scotch	804,789
Dark Eyes Fruit Flavored Vodka	3,522
Dark Eyes Vodka	14,876
David Nicholson 1843	16,203
Dewar's Ancestor Scotch	17,169
Dewar's White Label Scotch	829,268
Dickel Tennessee	23,080
Distillers Bond	831
Distillers Light	1,836
Distillers Pride	17,855
Dolfi French Cordials	17,659
Don Q Rum	44,858
Drambuie Liqueur	155,009

Figure 1. (continued)

Du Bouchett Brandy	$ 17,732
Du Bouchett Creme De Menthe	66,986
Du Bouchett Fruit Brandies	107
Du Bouchett Peppermint Schnapps	11,308
Duet Cocktails	32,910
Early Times	508,175
Echo Spring	75,603
Eldorado Rum	11,242
Embassy Club	41,313
Evan Williams	64,994
Ezra Brooks	163,841
Finlandia Vodka	16,354
Fleischmann's Gin	44,402
Fleischmann's (Multi-Products)	5,119
Fleischmann's Preferred	156,128
Fleischmann's Royal Vodka	17,860
Four Roses	630,461
Four Roses Distillers (Multi-Prod)	4,907
Free Spirit	47,950
Frost 8/80	624,076
G & W (Multi-Products)	148,010
G & W Private Stock	7,762
G & W Seven Star	33,121
Galaxy	64,127
Galliano Liqueur	136,455
Gaston De La Grange Cognac	37,135
George Dickel	106,605
Gilbey's Gin	29,760
Gilbey's Spey Royal Scotch	10,993
Gilbey's Vodka	18,241
Gordon's Gin	327,603
Gordon's (Multi-Products)	1,413
Gordon's Vodka	172,603
Governor's Club	29,936
Governor's Club (Multi-Products)	863
Grand Macnish Scotch	287,838
Grand Marnier Liqueur	49,468
Grande Canadian	340,653
Grant's Scotch	38,834
Haig Scotch	203,468
Haig & Haig Pinch Scotch	308,407
Haller's (Multi-Products)	33,576
Haller's Vodka	223
Harwood Canadian	317,163
Heaven Hill	40,280
Henry McKenna	110,718
Heublein Cocktails	932,646
Hill & Hill	27,396
Hiram Walker's Brandy	9,697
Hiram Walker's Cordials	252
HiramWalker's Gin	112,146

Hiram Walker's Little Brown Jug	$ 6,768
Hiram Walker's (Multi-Prod)	53,998
Hiram Walker's No.Light	36,891
Hiram Walker's Priv.Cellar	26,387
Hiram Walker's Spec.Can.	328,741
Hiram Walker's Vodka	538
House of Stuart Scotch	39,700
Hudson Bay Scotch	36,930
I. W. Harper	151,695
Igor The Invisible Liqueur	317,011
Igor Vodka	3,835
Imperial	696,874
Inver House Scotch	368,918
J&B Scotch	453,843
J. Bavet Brandy	18,362
J. W. Dant	108,808
J. W. Dant Charcoal Perf.	121,308
J. W. Dant (Multi-Prod)	61,346
J. W. Dant Olde Bourbon	36,754
Jack Daniels	257,160
Jacquin's Brandy	3,021
Jacquin's Cordials	446
Jacquin's Creme De Menthe	116
Jacquin's London Tower Gin	331
Jacquin's (Multi-Products)	7,855
Jacquin's Peppermint Schnapps	625
Jacquin's Rum	963
Jacquin's Vodka	1,023
Jameson Irish Whisky	13,695
Jim Beam	635.141
John Begg Scotch	127,082
Johnnie Walker Scotch	1,042,761
Jose Cuervo Tequila	43,648
Kasser's (Multi-Products)	84,222
Kamchatka Vodka	23,784
Kentucky Beau	143,974
Kentucky Tavern	215,763
Kessler	396,556
King George IV Scotch	13,535
King William IV Scotch	269,521
Laird's Apple Jack Brandy	1,317
Laird's Canadian	35,180
Lang's Scotch	67,478
Lauder's Scotch	264,875
Leilani Hawaiian Rum	19,234
Leroux Anisetts	11,158
Leroux Brandy	65,562
Leroux Coffee Brandy	8,998
Leroux Creme De Cacao	10,502
Leroux Creme De Menthe	28,609

Figure 1. (continued)

Leroux Liqueur	$ 2,656
Leroux Peppermint Schnapps	8,259
Leroux Sloe Gin	13,529
Leroux Triple Sec	4,150
Lochran Ora Liqueur	73,163
Lord Barry Scotch	11,465
MacNaughton	685,793
McColl's Scotch	58,689
McGills	40,488
McMaster's	103,396
McMaster's Scotch	56,840
Majorska Vodka	71,911
Maker's Mark	39,342
Mattingly & Moore	180,855
Metaxa Liqueur	133,619
Mr. Boston Brandy	8,135
Mr. Boston Cocktails	36,316
Mr. Boston Egg Nog	748
Mr. Boston Five Star	4,122
Mr. Boston Light	11,475
Mr. Boston (Multi-Products)	21,141
Mr. Boston Vodka	6,768
Muirhead's Scotch	95,570
National Distillers (Multi-Products)	31,348
Old Charter	180,627
Old Crow	250,080
Old Fitzgerald	163,310
Old Fitzgerald 1849	2,791
Old Fitzgerald Prime	164,908
Old Forester	410,432
Old Grand-Dad	376,249
Old Hickory	13,724
Old Master	10,589
Old Smuggler Scotch	145,540
Old Taylor	100,910
Old W. L. Weller	78,393
100 Pipers Scotch	800,860
Orange Driver	10,351
Ostrova Vodka	40,204
Park Avenue Imports (Multi-Products)	12,818
Park Avenue Liqueurs	6,135
Park & Tilford	3,950
Park & Tilford Spec.Selection Scotch	58,077
Party Tyme Cocktails	27,012
Passport Scotch	331,383
Paul Jones	50,079
Philadelphia	50,032
Plymouth Gin	48,794
Popov Vodka	154,221
Puerto Rican Rums	158,720
Rebel Yell	41,119
Relska Vodka	$ 160,499
Remy Martin Cognac	249,307
Renfield Dry Canadian	118,275
Renfield Imp.(Multi-Prod)	1,530
Ron Llave P.R. Rum	11,288
Ron Superior Rum	44
Ronrico Rum	208,638
Royal American	19,632
Royal Canadian	352,585
Royal Gate Vodka	13,783
Sabra Liqueur	61,390
St. Dennis Scotch	23,031
Sambuca Romana Liqueur	17,382
Sazerac	16,924
Sazerac (Multi-Products)	11,202
Schenley Brandy	710
Schenley Champion	37,925
Schenley Dist.(Multi-Prod)	2,232
Schenley (Multi-Products)	101,347
Schenley Reserve	306,282
Schenley XL	15,179
Schenley XL Light	13,440
Scotch Comfort	75,393
Seagram's Benchmark	282,183
Seagram's Crown Royal	53,330
Seagram's Distillers	2,168
Seagram's Dist.(Instutional)	24,656
Seagram's Seven Crown	1,693,375
Seagram's VO	1,113,230
Seagram's Gin	190,606
Seagram's (Multi-Products)	48,342
Sendai	21,811
Sir Malcolm Scotch	21,578
Smirnoff Gin	136
Smirnoff Vodka	514,554
Something Special Scotch	10,614
Southern Comfort	454,615
Squires Gin	12,599
Stock Brandy	114,795
Stock Cordials	34,762
Stolichmaya Vodka	28,968
Sunny Brook	43,533
Suntory Royal	17,182
Taaka Vodka	145,505
Tanqueray Gin	211,078
Teacher's Scotch	127,528
Ten High	406,262
Thorne's Scotch	38,853
Tia Maria Coffee Liqueur	23,634
Usher's Scotch	124,657
Vandermint Liqueur	89,917

Figure 1. (continued)

Vat 69 Scotch	$ 57,337
Verana Liqueur	51,630
Very Old Barton	63,915
Virgin Bourbon	11,633
Virgin Islands Rum	323.661
Waterfill & Frazier	8,670
Waterfill & Frazier(Multi-Products)	4,903
Walker's De Luxe	433,785
White Horse Scotch	74,821
White Wolf Vodka	20,319
Wild Turkey	303,714
William Lawson Scotch	16,056
William Penn	33,943
Wilson	14,105
Windsor Supreme	797,764
Wolfschmidt Vodka	177,967
Yellowstone	49,914
Zhivago Vodka	84,442
WINES:-Adriatica	13,547
Alexis Lichine	101,362
Alianca	11,100
Andre	295,150
Andre Champagne	88,565
Andre Cold Duck	134,475
Brotherhood Winery	47,564
Campari	61,634
Carillon	26,857
Chauvenet	28,968
Cockburns	22,398
Gallo	175,601
Gallo Champagne	111,401
Gallo Cold Duck	30,271
Hudson Valley Winery	20,159
Inglenook	16,207
Isabel Rose	22,789
Julius Kayser Wines	21,221
Lagosta	23,579
Lagosta Rose	5,519
Lancers Vin Rose	13,131
M. Lamont	37,268
Manischewitz	18,023
Mistala	23,488
Noilly Prat Vermouth	11,226
Paul Masson	168,599
Raphael	31,746
Romano	31,157
Stock Vermouth	73,514
BEERS:-Altes	12,053
Anheuser Busch Beers	63,311
Asahi	11,681
Ballantine	101,678
Ballantine Beer & Ale	508
Biber-Brau	10,848
Black Label	$ 7,825
Blatz	30,390
Brew 102	15,975
Budweiser	163,749
Burger	10,998
Busch Bavarian	60,946
Carling Black Label	44,390
Carling Brewing Co.	2,490
Carl. Bl.Label & Red Cap Ale	267
Carlsberg	44,790
Carta Blanca	22,309
Coors	22,890
Coors Co.(Institutional)	16,512
Coors Dist'g.(Institutional)	207
Falstaff	83,934
Guinness	15,285
Heidelberg-Alt	11,119
Heidelberg Beer	1,859
Hop N Gator	11,840
Hudepohl	26,482
Iron City	13,333
Jax	11,098
Jos.Schlitz Brewing Co.	7,584
Lowenbrau	53,158
Lucky Breweries(Institutional)	34
Lucky Lager	20,715
Malt Duck	38,697
Maximus Super	16,236
Miller Ale	6,134
Miller Brewing Co.	7,444
Miller Brewing (Institutional)	2,816
Miller High Life	43,257
Miller Malt Liquor	5,456
Molson	83,788
Molson Ale	50,481
Molson Ale & Beer	288
National	58,542
Old Milwaukee	17,495
Olympia	84,092
Olympia Brewing (Institional)	2,873
Pabst Blue Ribbon	74,932
Piels	29,082
Primo	29,392
Regal Select	23,792
Rheingold	111,951
Ruppert Knickerbocker	32,486
Schaefer	323,133
Schlitz	98,375
Schmidts of Philadelphia	24,398
Stag	45,090
Stroh Brewery (Institutional)	3,336
Strohs	73,712
Tuborg	78,573

Figure 2.

Following is the amount spent by liquor advertisers in 15 major magazines in 1973 and number of pages. (Source: PIB)

BEER, WINE & LIQUOR

DOLLARS

MAGAZINE	1973	1972	Difference Gain or Loss	% Dif.
Time	16,946,268	15,064,423	1,881,845	12.5
Newsweek	12,337,103	12,169,444	167,659	1.4
Playboy	8,911,830	9,454,819	- 542,989	- 5.7
Sports Illustrated	8,130,790	8,184,035	- 53,245	- .7
TV Guide	4,513,366	4,304,251	209,115	4.9
Esquire	4,307,545	4,060,821	246,724	6.1
US News & World Report	4,242,968	4,389,076	- 146,108	- 3.3
New Yorker	3,798,009	3,310,184	487,825	14.7
New York Magazine	2,234,114	1,494,435	739,679	49.5
Gourmet	1,884,173	1,544,813	339,360	22.0
Ebony	1,846,910	1,893,198	- 46,288	- 2.4
Cosmopolitan	1,545,093	1,331,009	214,084	16.1
Penthouse	1,371,413	429,783	941,630	219.1
Psychology Today	1,073,125	602,005	471,120	78.3
Southern Living	833,314	796,178	37,136	4.7
Total 15 Magazines	73,976,021	69,028,474	4,947,547	7.2
General Magazines	86,886,353	80,953,330	5,933,023	7.3
Newspaper Supplements	1,981,341	1,530,668	450,673	29.4
Total PIB Publications	88,867,694	82,483,998	6,383,696	7.7

PAGES

MAGAZINE	1973	1972	Difference Gain or Loss	% Dif.
New Yorker	479.22	440.72	38.50	8.7
Newsweek	427.65	463.88	- 36.23	- 7.8
Time	407.20	375.19	32.01	8.5
New York Magazine	397.27	295.45	101.82	34.5
Sports Illustrated	319.41	343.03	- 23.62	- 6.9
Esquire	290.90	269.59	21.31	7.9
Gourmet	224.90	190.07	34.83	18.3
US News & World Report	209.02	219.00	- 9.98	- 4.6
Playboy	191.28	212.53	- 21.25	- 10.0
Cue	185.24	189.77	- 4.53	- 2.4
Ebony	136.91	152.81	- 15.90	- 10.4
Cosmopolitan	134.18	127.06	7.12	5.6
Harpers Magazine	117.61	121.74	- 4.13	- 3.4
Atlantic	109.28	129.73	- 20.45	- 15.3
Southern Living	103.10	118.59	- 15.49	- 13.1
Total 15 Magazines	3,733.17	3,649.16	84.01	2.3
General Magazines	5,100.09	4,805.34	294.75	6.1
Newspaper Supplements	244.93	191.64	53.29	27.8
Total PIB Publications	5,345.02	4,996.98	348.04	7.0

LIQUOR

MAGAZINE	DOLLARS 1973	1972	Difference Gain or Loss	% Dif.
Time	15,452,050	13,375,709	2,076,341	15.5
Newsweek	11,044,734	10,843,408	201,326	1.9
Playboy	8,010,830	8,061,436	- 50,606	- .6
Sports Illustrated	7,574,363	7,336,049	238,314	3.2
TV Guide	4,439,540	3,532,962	906,578	25.7
US News & World Report	3,929,728	4,099,935	- 170,207	- 4.2
Esquire	3,888,293	3,636,855	251,438	6.9
New Yorker	3,104,931	2,677,670	427,261	16.0
New York Magazine	1,842,457	1,219,920	622,537	51.0
Ebony	1,566,581	1,625,517	- 58,936	- 3.6
Cosmopolitan	1,319,593	1,051,309	268,284	25.5
Gourmet	1,267,560	1,080,660	186,900	17.3
Penthouse	1,223,888	333,315	890,573	267.2
Psychology Today	868,350	439,375	428,975	97.6
Southern Living	771,024	735,470	35,554	4.8
Total 15 Magazines	66,303,922	60,049,590	6,254,332	10.4
General Magazines	77,067,379	68,958,725	8,108,654	11.8
Newspaper Supplements	1,521,587	1,251,644	269,943	21.6
Total PIB Publications	78,588,966	70,210,369	8,378,597	11.9

MAGAZINE	PAGES 1973	1972	Difference Gain or Loss	% Dif.
Newsweek	382.66	415.68	- 33.02	- 7.9
New Yorker	377.58	340.05	37.53	11.0
Time	372.98	336.84	36.14	10.7
New York Magazine	322.35	232.26	90.09	38.8
Sports Illustrated	298.97	309.23	- 10.26	- 3.3
Esquire	261.55	240.93	20.62	8.6
US News & World Report	193.20	205.21	- 12.01	- 5.9
Playboy	173.14	183.75	- 10.61	- 5.8
Cue	149.00	169.47	- 20.47	- 12.1
Gourmet	145.71	126.31	19.40	15.4
Ebony	115.26	131.06	- 15.80	- 12.1
Cosmopolitan	114.51	101.07	13.44	13.3
Southern Living	95.44	110.32	- 14.88	- 13.5
TV Guide	82.63	73.32	9.31	12.7
Psychology Today	81.66	49.34	32.32	65.5
Total 15 Magazines	3,166.64	3,024.84	141.80	4.7
General Magazines	4,317.36	3,899.16	418.20	10.7
Newspaper Supplements	182.15	153.49	28.66	18.7
Total PIB Publications	4,499.51	4,052.65	446.86	11.0

In the face of these statistics, we believe that rare instances of industry advertising which highlight the need for responsible drinking do not suffice. Occasional black and white pages in a magazine warning against overindulgence which are sandwiched between glorious full-color promotional materials for name brands are inferred to have no impact whatever. We firmly recommend that the publishers of newspapers and magazines reevaluate their positions with regard to requiring cautionary notices on liquor advertisements. We also recommend that the United States Treasury Department, the Federal Trade Commission and the Surgeon General's Office evaluate the possibility of a requirement that bottle labels carry similary cautionary notices.

We believe that even if such cautionary notices did not actually reduce overindulgence, they would heighten the credibility of those charged with the responsibility for discouraging all forms of substance abuse.

DRUGS

Our first apprehension that public service media advertisements against illicit drug use were not only ineffective, but were positively dangerous, arose when we were studying the possibility of using media campaigns to stimulate employment opportunities for rehabilitated addicts. At that time, we received a considerable amount of information that anti-drug advertisements were ineffective. For example, from Dr. Daniel X. Freedman, we heard: "Almost all of the drugs in illegal currency today require a belief or faith on the part of the user that they are going to make him feel better. Once having made that commitment, it is highly unlikely that a user will quit on the basis of advertising. What advertising can do is to provide reasonable options for not taking drugs in the first place."

Because most advertisers have abandoned the concept of the "soft sell", experts at merchandising consumer items recommended that agencies such as the New York State Drug Abuse Control Commission and the New York City Mayor's Council on Drugs, sponsor hard-hitting, sloganeering messages on television, on billboards, in magazines and newspapers, and in specially prepared pamphlets.

When we spoke with employers about hiring reformed addicts, we found that a number of them had been persuaded, at least in part, by such advertisements as "Don't Join the Living Dead" and "Why Do You Think They Call It Dope?" that addicts were fools who could never effectively be rehabilitated. We pursued this line of inquiry and found widespread agreement among treatment experts that such advertisements were counter-productive and that by lowering the self-esteem of drug users even further, they were deterrents to abstinence and rehabilitation, rather than to drug use.

Some of the anti-drug commercials defied credibility and others aroused great anger. Youngsters universally reacted with disbelief when told by athletes whom they suspected of using drugs that drug use was bad. Residents of poorer neighborhoods reacted with a sense of outrage when commercials appeared warning rich youngsters of the penalties for drug use in other countries. We found that both types of announcements weakened the status of those in authority truly concerned about substance abuse.

Testimony throughout the state at our public hearings regarding prevention has confirmed these findings. However, the last sentence quoted from Dr. Freedman seemed to us to contain the germ of an idea: "What advertising can do is to provide reasonable options for not taking drugs in the first place."

One out of every six commercials* on television deals with some form of drug or chemical. At least ten percent of the advertising revenue of broadcasters derives from the promotion of such products. Although there is no proof that such advertising actually encourages the misuse of drugs, there is a great deal of evidence that unnecessary use of drugs and chemicals (with resultant profits to their manufacturers) is the goal of such advertising. Recently, Bristol-Myers sponsored a program narrated by Joanne Woodward and entitled "The Fragile Mind -- Five Cases of Emotional Stress". Everyone would agree that the subject matter was extremely sensitive. During the course of the program, which lasted but one hour, there were two commercials for Excedrin, two commercials for Excedrin P.M., one commercial for Congespirin, three commercials for anti-perspirants, one commercial for a hair-spray, one commercial for a nasal spray, one commercial for Bufferin and one commercial for a cough syrup (Silence is Golden). All in one hour. If television drug commercials have no market-expansion effect, why are there so many of them?

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*In prime time.

It is true that broadcast drug advertising is tightly regulated, both by the Federal Trade Commission and by the broadcast industry. The Federal Trade Commission sees to it that drug commercials are true, in terms of claims made for specific products. For example, the FTC has taken action against producers of headache remedies who advertise their product, either directly or indirectly, for relief of tension. This form of advertisement leads the viewer to believe that a combination of aspirin and caffeine can ease daily anxieties, and, what is more, that daily anxieties should be eased chemically rather than through problem-solving. When the FTC brought their action, the sponsor, a subsidiary of one of the largest corporations in the world, quickly changed the commercials to moot the issue. Now they advertise their headache remedy as one which will "hit and hold the highest level" of pain relief. A number of authorities have questioned whether these new commercials use language to hint that the product can produce a "high."

Although the FTC does a brilliant job in assuring that most commercials will be truthful, it cannot possibly keep up with the shifting techniques of advertisers, who can change commercials quickly and often. After having been criticized for advertising a stomach and headache remedy by inventing an illness called "The Blahs", to expand the market for the drug, a manufacturer produced a series of entertaining comic spot announcements. Soon thereafter, however, it aired a commercial which carried the message that the product would bring relief from the discomfort of noise and anxiety. Criticized again, the manufacturer now airs a sober series of commercials cautioning viewers that the product is strong medicine and should not be used "for every little ache and pain." But what ingenious commercial will they air tomorrow?

Moreover, the FTC does not have the power to regulate the frequency of drug commercials. As one witness commented at our hearing in Poughkeepsie, "We may have reached the point where we have more commercials for headache remedies than there are headaches." Except for persons employed by the media, all of the witnesses at our hearings recommended action to somehow curtail or counteract this deluge of drug commercials. Witnesses pointed out that many over-the-counter chemical products are really quite dangerous, especially to children. Restrictive warnings required on labels, such as "Keep product away from eyes", or "Keep out of the reach of children" are never aired. Recently, as an incident of broadcast industry self-regulation, notices have begun to appear on drug product commercials that they should be used according to label instructions.

Arguably, this does not go far enough. In nearly all of the contexts in which headaches are depicted on television, drug remedies are sold. In nearly all of the contexts in which digestive problems or irregularity are seen on television, non-prescription drugs are sold. In nearly all of the contexts in which sleeplessness is represented on television, or lack of alertness, drug remedies are sold. In nearly all of the contexts in which colds, hay fever, sore throats, muscle aches, stiffness or virtually any discomfort, short of a debilitating illness, are depicted on television, drug products are sold. No group of commercials fosters the concept that social acceptance depends on chemical use more than the deodorant, mouth wash and anti-bacterial soap advertisements. And these messages appear in the context of continuing advertisements for cigars, beer and wine.

While the need exists for self-medication, the dangers of reliance upon drugs, rather than upon prevention and alternative forms of relief, have never been clearly spelled out on television. Physicians believe that exercise and roughage are far more acceptable remedies for temporary irregularity than laxatives. Hot milk and the completion of routine household tasks remain preferable remedies for sleeplessness than drugs. And the depiction of persons warmly dressed, rather than, as in some cold remedy commercials, inadequately clothed for winter, would be preferable as a concept of cold prevention to the depiction of the illness and the drug alone.

The Federal Communications Commission, which regulates all broadcasting, has established a policy known as "the fairness doctrine". The fairness doctrine requires that over a period of time, matters in controversy shall be dealt with on television in such a way that all reasonable positions and points of view are represented. We find that the volume of drug advertising on television, and its content, which always depicts discomfort in terms of chemical remedies, violates the fairness doctrine by presenting only one view of self-medication, good health and preventive medicine: the view of the pharmaceutical manufacturer.

We recommend that the Federal Communications Commission require, as it once did before when cigarettes were still being advertised on television, that the broadcast media make free time available (in prime time) for spot announcement counter-commercials to respond to the underlying assumptions of the drug commercials. Such counter-commercials would not refer to drugs at all. They would reply directly to the sales techniques of the drug commercials by demonstrating methods of preventing discomfort and minor illnesses, as well as methods of gaining relief from such problems as sleeplessness and irregularity. We believe fairness dictates that if pharmaceutical manufacturers should be free to offer home remedies for truthful sale, then others without a profit motive should be equally free to inform the public why such products may not be necessary.

AFTERWORD: ON VALUES AND FUNDING PRIORITIES

Many of those who replied to the Commission's questionnaires and letters of inquiry regarding prevention of drug abuse, and who testified at the hearings on this subject, addressed themselves to the broad alternatives to drug abuse which are required, and to the change in our value system which is necessary to obtain these alternatives. Since a nation's dominant value system is graphically expressed in the funding priorities of its government, talk of values is not so abstract as it may sound.

When this Commission speaks of values, we speak of what the policy makers consider important and what they are willing to pay for. We speak of young Americans' awareness of official confusion in this area, and their consequent loss of respect for authority figures. We speak of the hopelessness of the poor and of the malaise of purposelessness which affects the middle class.

Some of the answers the Commission received follow:

ON SOCIAL PROBLEMS:

From a Drug Rehabilitation Center:

"Conceptually, the most significant approach to prevention would be the meaningful beginnings of social change, that is, creating the stimulus within depressed communities (where drug-abuse is highest) towards education, decent housing and employment. Traditionally the use of welfare monies has been the approach to remedy the ghetto problems. It simply has reinforced the hopelessness associated with that life-style. In my opinion change could be effected if the recipients of public assistance received grants for efforts made, in education and the completion of same, in housing and the "cooperative" maintenance of same, all of which would certainly be tapping the resourcefulness and potential of people, and ultimately the reality of one's ability to compete, complete and live as productive members of the larger society. Drugs are not a cop-out when there is no hope, no self-esteem, no beliefs."*

From a Child Care Agency:

"From the point of view of causation, we believe that many factors contribute to drug abuse. Among them are socio-economic pressures stemming from conditions of poverty. Here the consequent sense of hopelessness and helplessness about oneself and society may influence many young people to seek escape from reality through drug induced satisfaction and fantasies. There are many other motivations. Among them are, a pressing curiosity to experiment, a need to be 'in' and 'cool,' as part of a particular peer culture, it may be an expression of rebelliousness or defiance as part of adolescent development, a protest against existing adult values, a manifestation of underlying conflict with parents or an expression of serious emotional disturbance."**

From a Private Practitioner, on the Necessity of Employment:

"I have very rarely seen a drug abuser who had a salable skill and was able to hold down a job. I think that we prohibit the entry into job training until a point at which many youngsters become disenchanted with school. In this regard, the unions are in part to blame as are the schools. I see no reason why a youngster could not enter into junior apprenticeship at the age of sixteen rather than waiting until high school graduation at the age of eighteen and why he could not be given credit for his first years of training in the union apprenticeship. I know a training program for practical nurses in New York City, under the New York City Board of Education, has been successful, in which girls in their junior year of high school are started in practical nurse training so that by the time they graduate from high school, they not only have an L.P.N. but also their high school diploma. I think we keep too many non-school oriented children in school too long and offer them no satisfactory alternatives to the school learning situation. I believe the job learning situation is a satisfactory one and that school credit might be given for this. Certainly the growth of alternative schools should make clear the fact that the standard school situation is lacking for some students. I believe that every youngster can and should be able to succeed at something and to persist in holding him in a situation where he is failing can only result in his turning to other forms of satisfaction which may include alcohol, drug abuse or other forms of sociopathy....

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* Sherman, Bernard, Executive Director, Ardis Commune, Inc., Letter of Aug. 23, 1973.

**Rabinow, Irving, Associate Executive Director, Jewish Child Care Association, Letter of Aug. 22, 1973.

"...my earlier comments are referred to work programs in which schools, business and industry cooperate to find job placements for the students and school credit for the students and perhaps further learning experience for the students either on the job or in school."*

From a Community Mental Health Clinic:

"Some of the factors which are important in the development of drug and alcohol abuse are the lack of recreational and social facilities in our country for both youth and adults; lack of acceptable social outlets and the low socio-economic conditions in our area."**

ON PERSONAL PROBLEMS AND VALUES:

On Responsibility:

"Perhaps the best place to begin is to examine closely an important misconception widely held by much of society and one which we believe to be a crucial point for discussion, i.e., the belief that drug abuse is the problem in and of itself. We believe the fallacy lies in not understanding that it is merely symptomatic of other existing problems.

"How this misconception has come about is not surprising when one examines the society at large. We feel strongly that we are living in a society that is extensive in its drug orientation and that this is evidenced by the emphasis placed upon using drugs in some form for 'any occasion.' A quick look at the media, for example, immediately identifies its role in perpetrating this misconception and gives a clearer picture as to how society has whole-heartedly embraced it. We are constantly being advised and sometimes

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* Morgenstern, Leo L., M.D. Letter of Dec. 5, 1973.

**Bassiri, Reza G., M.D., Director, Fulton County Community Mental Health Clinic.

commanded to use drugs whenever we don't feel 'right.' If you can't sleep - take a barbiturate; if you can't wake up - take an amphetamine; if you have a headache - take an aspirin, etc., etc. And always without question. Rarely are we directed to search for why we can't sleep or why we have a headache. The emphasis is placed upon not taking responsibility for ourselves in dealing with our own problems, but instead in placing that responsibility somewhere else - too often on drugs."*

On Goals and Motivations

From Dr. Henry Brill:

"I think that the most serious lack in our present structure is a lack of provision for development of positive social and personal goals. At one time this was a function of religion. Subsequently it was in part taken over by patriotism. The tremendous Chinese successful control of opium addiction can, I think, be attributed primarily to the acceptance of strong social and individual goals by the total population. We do not seem to have a broadly effective system for creating such goals today."**

From a Drug Rehabilitation Agency:

"The emphasis should be on motivation! Human problems must be solved in human ways. Drug abuse is a distinctively human problem. The solution must come from involvement of the individual with interested role models who can satisfy their own needs within society without resorting to drugs and who can help others to find alternative ways to meet their needs without drugs. Peer group involvement is essential and must supplement didactic instruction."***

From a Medical Center:

"We have tried all the ineffective approaches to drug abuse prevention and only by very broadly defining 'improvement' can we claim a reasonable percentage of favorable results.

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* Davidson, Richard B., and Lenney, Sandy, Outreach Workers, The Cheektowaga Drug Education and Counseling Center of the Young Men's Christian Association of Buffalo and Erie County, Letter of Oct. 15, 1973.

** Brill, Henry, M.D., Director, Pilgrim State Hospital, Letter of Aug. 13, 1973.

***Curry, Andrew P., Administrator, Daytop Village, Inc., Letter of June 11, 1973.

If we ask how many non-users has each ex-addict brought about - as compared to how many users created while traveling in the other direction - we see that cure is not as infectious as addiction. I am sure if we research why, we will get involved in social motivation - and we should."*

On One's Sense of Worth

From New York City:

"When we speak of prevention in the area of drug abuse, it seems we mean to arm youngsters with the knowledge to make meaningful choices; problem solving and social skills necessary for life in our complex society and a sense of worth about himself, his fellows and their institutions."**

From Oneida:

"If the State wants to be truly effective in this whole area of prevention, cure, and rehabilitation - I heartily recommend findings ways to develop 'grass roots' groups where persons can be taken seriously as persons and their needs dealt with on a personal level."***

On Self Worth and Social Needs:

"First of all, I believe that drugs are used to compensate for feelings of ineffectiveness. Thus, inability to achieve in the school, at the job, or in our success-oriented society generally would seem to me to be the strongest contributing factor to the use of drugs....

"If the 'help' that we provide could be more responsive to the individual's needs as the individual perceives

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* Kurian, Milton, M.D., F.A.P.A., Medical Director, Department of Psychiatry, New York University Medical Center, School of Medicine, Letter of September 6, 1973.

** Lembo, Philip G., Assistant Director, District 20 Narcotics Program, N.Y.C. Board of Education, Letter of Aug. 21, 1973.

***McCleary, Stewart, Member, Narcotics Guidance Council, Oneida County.

> those needs, I believe we could intervene much more effectively. That is, when the person cites a lack of job skills, inadequate housing, etc., we should not think that counselling alone will provide assistance."*

> ONE SUGGESTION:

> "Drugs, alcohol, delinquency and crime - all facets of the same problem: the inability to meet one's needs within the tolerance of society while allowing others to meet their needs. Since one individual may and often does evidence all these symptoms, we may be myopic in attempting to treat each as a discrete entity and we do so through the limitations of our drug programs, penal systems, alcohol programs, etc. Why not create private programs with the authority to command the resources of all governmental agencies, political and administrative, to assure coordination."**

AND A NOTE OF OPTIMISM:

"I think for too long problems such as drug abuse have been dealt with as if they have no ideological tie to the basic fabric of our society...

"It seems to me that we know an awful lot more about what needs to be done to deal with the problems of our modern society. We know that our educational system is failing. We know that our public welfare system metes out miserly grants that are totally inadequate for human existence. We know that our criminal justice system is at best punitive and abusive. We know that social agencies have functioned with an uneven level of success and have given

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*Blum, Barbara B., Assistant Administrator, Special Services for Children, N.Y.C. Human Resources Administration, Letter of Sept. 4, 1973.

**Curry, Andrew, op. cit. Letter of July 9, 1973.

little of their effort towards direct services in urban ghetto communities, and we know that government and, yes, our society in general has not demonstrated a commitment to a decent life and a fair chance of survival for all of its constituents. Once there is commitment, it isn't too difficult to decide what needs to be done. Once one gets past the political and self-interest reasons for tangentially relating to problems such as drug abuse, we know what should be done.

"It is when state governments and federal government give leadership and face squarely the need to infuse our many communities with the life blood of services and opportunities that we can begin to talk about solving the problem of drug abuse."*

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*Silcott, T. George, Executive Director, Wiltwyck School for Boys, Letter of Nov. 14, 1973.

APPENDIX

MEMORANDUM

AN ACT to amend the vehicle and traffic law, the penal law, the criminal procedure law and the mental hygiene law relating to the establishment of a New York State Driving Under the Influence of Alcohol Countermeasures Program.

Purpose of the Bill:

To create a New York state Driving Under the Influence of Alcohol Countermeasures Program to provide instructional, counseling, health and mental health services to persons convicted of alcohol-related traffic offenses, and others interested in taking advantage of such program.

Summary of the provisions of the Bill:

Bill section one amends the Vehicle and Traffic Law to provide an alternative to automatic revocation of the license of a person convicted of driving while his blood-alcohol content equals or exceeds .10 of one per centum by weight or while he is in an intoxicated condition. The alternative is participation in a Driving Under the Influence of Alcohol Countermeasures Program.

Bill section two incorporates two technical amendments necessitated by the addition of a new clause.

Bill section three requires the commissioner of motor vehicles, and other authorized persons, to suspend, rather than revoke, the license of a person convicted of such offenses provided the defendant participates in a Driving Under the Influence of Alcohol Countermeasures Program. The license of such person shall be suspended until he demonstrates a need to have it temporarily restored or, absent such a showing of need, until he has satisfactorily completed the program.

Bill section four provides that the commissioner of motor vehicles may not issue a new license or restore an old one to a person convicted of such offenses unless he participates in a Driving Under the Influence of Alcohol Countermeasures Program, either as a condition of probation or independently.

It also amends the subdivision to prohibit the reissuance or restoration of a license of a person twice convicted of driving while intoxicated or while his ability to do so was impaired by the use of a drug, when personal injury has resulted in the second, rather than in each, instance.

Bill section five directs the commissioner of motor vehicles, jointly with the commissioner of mental hygiene, to establish a Driving Under the Influence of Alcohol Countermeasures Program in each of the four judicial districts of the Supreme Court. It provides for the appointment of directors and the selection of program personnel, and requires that participation be open to the general public. The proposal specifies the requirements for satisfactory completion of the program and requires the director to make a written report to the court concerning completion of the program by persons whose participation has been imposed as a condition of adjournment in contemplation of dismissal or as a condition of probation. It provides that the suspension, revocation, or restoration of the license and certificates of registration of persons convicted of such offenses is to be conditioned upon their status in the program. Thus, the commissioner must revoke the license of a defendant who has not participated in the program and may not issue a new license or restore an old one until the defendant has so participated. The commissioner must suspend the license of a defendant who is participating in the program. However, he must restore such license upon satisfactory completion of the program and may restore it before satisfactory completion if the defendant makes a showing of need, such as the need to operate a motor vehicle to attend to his job or to participate in the program.

Bill section six repeals subdivision five of section eleven hundred ninety-two and enacts a new subdivision five which will control the disposition of persons convicted of violating the provisions of that section. The dispositions authorized for a person convicted of driving while his ability to do so was impaired by the use of alcohol remain unchanged.

A first offense of driving while blood-alcohol content equals or exceeds .10 of one per centum or of driving while in an intoxicated condition will remain an unclassified misdemeanor but will be punishable only by imprisonment for ninety days or by probation conditioned upon participation in a Driving Under the Influence of Alcohol Countermeasures Program. No alternative dispositions are authorized.

A second conviction of either of such offenses, within ten years, will remain a class E felony, which will be punishable only a) by a sentence of imprisonment, the minimum term of which has been increased from sixty to ninety days; or b) by a fine, the minimum amount of which has been increased from two hundred to five hundred dollars; or c) by both such fine and imprisonment; or d) by a period of probation conditioned upon participation in a Driving Under the Influence of Alcohol Countermeasures Program. No alternative dispositions are authorized.

A first conviction of driving while the ability to do so was impaired by the use of a drug remains an unclassified misdemeanor and the authorized dispositions remain unchanged. A second conviction of such offense, within ten years, remains a class E felony. However, the authorized minimum period of imprisonment will be increased from sixty to ninety days and the authorized minimum fine will be increased from two hundred to five hundred dollars.

Bill section seven incorporates a number of technical amendments necessitated by the addition of a new paragraph to subdivision three of section 65.00 of the penal law.

Bill section eight adds a new paragraph to subdivision three of section 65.00 of the penal law, to provide that the period of probation imposed upon a person convicted of an alcohol-related traffic offense shall terminate upon satisfactory completion of a Driving Under the Influence of Alcohol Countermeasures Program, and compliance with the other conditions of probation.

Bill section nine revokes the court's authority to impose a sentence of conditional discharge upon a person convicted of driving while his blood-alcohol content exceeds .10 of one per centum or of driving while in an intoxicated condition.

Bill section ten requires that a person convicted of such offenses participate in a Driving Under the Influence of Alcohol Countermeasures Program as a special condition of probation. It directs the sentencing court to notify the director of the imposition of such sentence.

Bill section eleven amends the criminal procedure law to provide that, when the court orders adjournment in contemplation of dismissal in such cases, it shall require, as a condition of such adjournment, that the defendant participate in a Driving Under the Influence of Alcohol Countermeasures Program. It directs the court to notify the director of such adjournment.

Bill section twelve amends section 9.03 of the mental hygiene law to direct the commissioner of mental hygiene to assist in the establishment of a Driving Under the Influence of Alcohol Countermeasures Program.

Justification of the Bill:

This proposal represents a recommendation of the Temporary State Commission to Evaluate the Drug Laws embodied and fully detailed in its report to the Governor and to the Legislature: Drug Abuse Prevention, Legislative Document No. 11, 1974.

The recommendation is that New York should adopt the Dade County (Florida) Driving Under the Influence of Alcohol Countermeasures Program, which has reduced drunken driving recidivism in Dade County from twenty percent to three percent. The Dade County model was based upon an earlier successful experiment in Phoenix, Arizona. It is now being expanded to encompass the entire state of Florida.

The thrust of the program is to force persons found to be driving while intoxicated to learn a great many specifics about alcohol, driving and themselves. For this reason, the recommendation is that both the commissioners of motor vehicles and mental hygiene, who have responsibility, respectively, for traffic safety and for alcoholism prevention and rehabilitation, establish the program.

The Temporary State Commission to Evaluate the Drug Laws has found that there is widespread public understanding and acceptance of the proposition that reliance on alcohol and irresponsible drinking constitute the most serious drug problem in the state. However, it is often true that only when vigorous law enforcement and extremely pointed rehabilitation demonstrate to an individual that he is in fact part of the problem can he actually learn to refrain from drinking irresponsibly in the context of operating a motor vehicle.

In some parts of the State, the current practice with regard to a variety of traffic offenses is to adjourn the action in contemplation of dismissal or to place the offender on probation. As a condition of such adjournment or probation, some defendants are required to participate in a Driver Rehabilitation Program, established pursuant to section 521 of the vehicle and traffic law.

In other parts of the State, participation in the Driver Rehabilitation Program is offered to individuals subsequent to their conviction and contemporaneously with the imposition of a fine. There are two types of courses offered: one for people with severe drinking problems and one for other offenders.

This bill would formalize, by statute, the participation of persons charged with or convicted of alcohol-related traffic offenses. It would expand the scope of the programs designed for drivers who are problem drinkers by permitting participation prior to conviction and, in some cases, prior to the filing of a misdemeanor information.

It would also open the program to the general public and, thus, with the additional revenue, be self-supporting.

In place of a fine, there is an across-the-board registration fee of $50.

Fiscal implications of the Bill:

The fact that the program is open to the general public and that a registration fee of $50 will be required of most participants should render the program self-supporting, as in Florida.

Effective date of the Bill:

September 1, 1975.

AN ACT to amend the vehicle and traffic law, the penal law, the criminal procedure law and the mental hygiene law relating to the establishment of a New York state Driving Under the Influence of Alcohol Countermeasures Program.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Clause (iii) of paragraph a of subdivision two of section five hundred ten of the vehicle and traffic law, such clause having been last amended by chapter two hundred seventy-five of the laws of nineteen hundred seventy, is hereby amended to read as follows:

(iii) of any violation of subdivisions two [,] or three [or four] of section eleven hundred ninety-two, unless such holder complies with the requirements of subdivision three of section five hundred twenty-four of this chapter, or of any violation of subdivision four of section eleven hundred ninety-two, section six hundred or section three hundred ninety-two or of a local law or ordinance making it unlawful to operate a motor vehicle while in an intoxicated condition, or to leave the scene of an accident without reporting, or an offense consisting of operating a motor vehicle while under the influence of intoxicating liquor or drugs where the conviction was had outside this state;

§2. Clauses (iv) and (v) of paragraph b of subdivision two of section five hundred ten of such law, such paragraph having been last amended by chapter one hundred fifty-six of the laws of nineteen hundred seventy-three, are hereby amended to read, respectively, as follows:

(iv) when the holder forfeits bail given upon being charged with any of the offenses mentioned in this subdivision, until the holder submits to the jurisdiction of the court in which he forfeited bail; [and]

(v) such certificates of registration shall be suspended when necessary to comply with subdivision eight of section sixty-three-y of the public service law [.]; and

§3. Paragraph b of subdivision two of section five hundred ten of such law, such paragraph having been last amended by chapter one hundred fifty-six of the laws of nineteen hundred seventy-three, is hereby amended by adding thereto a new clause, to be clause (vi), to read as follows:

(vi) when the holder is convicted of a violation of subdivisions two or three of section eleven hundred ninety-two, until such time as he has complied with the requirements of subdivision three or subdivision five of section five hundred twenty-four of this chapter.

§4. Subdivision six of section five hundred ten of such law, such subdivision having been last amended by chapter eleven hundred six of the laws of nineteen hundred seventy-one, is hereby amended to read as follows:

6. Restrictions. Where revocation is mandatory hereunder, no new license shall be issued for at least six months or, in certain cases, a longer period as specified in this chapter, after such revocation, nor thereafter, except in the discretion of the commissioner of motor vehicles [, and such]. The commissioner shall not issue a new license, nor restore the old, in any event, where a person has been convicted of a violation of subdivisions two or three of section eleven hundred ninety-two and has not participated in the Driving Under the Influence of Alcohol Countermeasures Program established pursuant to section five hundred twenty-four of this chapter and where a person has been twice convicted of driving a motor vehicle or motorcycle while intoxicated or while his ability to operate such motor vehicle is impaired by the use of a drug as defined in this chapter where personal injury has resulted from such driving while intoxicated or where such driving has been impaired by the use of a drug as defined in this chapter in [each] the second instance. Where revocation is mandatory hereunder, based upon a conviction had outside this state, no new license shall be issued until after sixty days from the date of such revocation, nor thereafter, except in the discretion of the commissioner. Where revocation is mandatory hereunder based upon a conviction of a person under the age of twenty-one years for operating a motor vehicle or motorcycle while in an intoxicated condition or while his ability to operate a motor vehicle is impaired by the use of a drug as defined in this chapter, no new license in any case where the issuance thereof or the restoral of the license revoked is not

prohibited shall be issued for at least six months after such revocation or until such person reaches the age of twenty-one years, whichever is the greater period of time, nor thereafter, except in the discretion of the commissioner. Where revocation is permissive, no new license or certificate shall be issued by such commissioner to any person until after thirty days from the date of such revocation, nor thereafter, except in the discretion of the commissioner after an investigation or upon a hearing, provided, however, that where the revocation is based upon a failure in a reexamination pursuant to subdivision eight of section five hundred one of this chapter, a learner's permit may be issued immediately and provided further, that where revocation is based upon a conviction of a felony, other than a felony relating to the operation of a motor vehicle or motorcycle, a license may be issued immediately, if the application for such license is accompanied by consent in writing issued by the parole or probation authority having jurisdiction over such applicant.

§5. The vehicle and traffic law is hereby amended by adding thereto a new section, to be section five hundred twenty-four, to read as follows:

§524. Driving under the influence of alcohol countermeasures program

1. The commissioner and the commissioner of mental hygiene shall, by joint regulation, cause to be established, in each judicial district of the Supreme Court, not later than September first nineteen hundred seventy-five, a program to be designated as

the New York state Driving Under the Influence of Alcohol Countermeasures Program. The director of such program in each judicial district and such assistants and such staff as may be necessary shall be appointed and may be removed by agreement of the commissioner and the commissioner of mental hygiene. Standards for qualifications of the personnel in the programs shall be established by agreement between the commissioner and the commissioner of mental hygiene.

2. Such programs shall be open:

(a) to participation by the general public;

(b) to participation by persons charged under subdivisions two or three of section eleven hundred ninety-two of this chapter, as a condition of an "adjournment in contemplation of dismissal" pursuant to section 170.55 of the criminal procedure law; and

(c) to participation by persons convicted of violations of subdivisions two or three of section eleven hundred ninety-two of this chapter and sentenced to a period of probation.

3. Satisfactory completion of the Driving Under the Influence of Alcohol Countermeasures Program shall be determined by:

(a) attendance in an abstinent condition at not less than thirteen hours of classroom instruction, or makeup sessions, in the case of unavoidable absence;

(b) completion of all in-class and homework assignments;

(c) utilization of counseling, health or mental health services, as may be reasonably required by the program directors; and

(d) unless otherwise ordered by the court, payment of a registration fee of fifty dollars.

4. Within sixty days after receipt of an order of the court requiring participation in such program as a condition of adjournment in contemplation of dismissal or as a condition of probation, the director of such program shall report to the court in writing concerning the satisfactory completion of the program by the defendant.

5. Notwithstanding any inconsistent provision of this chapter, the enforcement of any suspension order arising from a conviction of a violation of subdivisions two or three of section eleven hundred ninety-two may be stayed, provided that the defendant participates in the Driving Under the Influence of Alcohol Countermeasures Program and establishes a need to have his license and certificates of registration temporarily restored.

6. Notwithstanding any inconsistent provision of this chapter, the commissioner shall restore the license and certificates of registration of a person who has satisfactorily completed the Driving Under the Influence of Alcohol Countermeasures Programs.

7. The commissioner shall revoke the license and may revoke the certificates of registration of a person convicted of a violation of subdivisions two or three of section eleven hundred ninety-two of this chapter who has not satisfactorily completed the Driving Under the Influence of Alcohol Countermeasures Program. In such event, the commissioner shall not issue a new license, nor restore the old until the person has satisfactorily completed such program.

§6. Subdivision five of section eleven hundred ninety-two of such law, such subdivision having been added by chapter two hundred seventy-five of the laws of nineteen hundred seventy, is hereby repealed and a new subdivision, to be subdivision five, is inserted therein, in lieu thereof, to read as follows:

5.a. A first conviction of a violation of subdivisions two or three of this section shall be a misdemeanor and, notwithstanding any inconsistent provision of the penal law, shall be punishable only in the following manner:

(i) by imprisonment in a penitentiary or county jail for ninety days; or

(ii) by a period of probation pursuant to article sixty-five of the penal law.

b. A person who operates a vehicle in violation of subdivisions two or three of this section after having been convicted of a violation of subdivisions two or three of this section, or of driving while intoxicated, within the preceding ten years, shall be guilty of a felony and, notwithstanding any inconsistent provision of the penal law, any such violation shall be punishable only in the following manner:

(i) by imprisonment in a penitentiary or county jail for not less than ninety days nor more than two years; or

(ii) by a fine of not less than five hundred dollars nor more than two thousand dollars; or

(iii) by both such fine and imprisonment; or

(iv) by a period of probation pursuant to article sixty-five of the penal law.

c. When a sentence of probation is imposed pursuant to paragraphs a or b of this subdivision, the court shall require, as a condition thereof, that the defendant must participate in a Driving Under the Influence of Alcohol Countermeasures Program established pursuant to section five hundred twenty-four of this chapter. When a sentence of probation is imposed pursuant to paragraphs a or b of this subdivision, the period of probation shall terminate upon satisfactory completion of such program.

d. A violation of subdivision four of this section shall be a misdemeanor and shall be punishable by imprisonment in a penitentiary or county jail for not more than one year, or by a fine of not more than five hundred dollars, or by both such fine and imprisonment.

e. A person who operates a vehicle in violation of subdivision four of this section, after having been convicted of a violation of subdivision four of this section, or of driving while his ability is impaired by the use of drugs within the preceding ten years, shall be guilty of a felony, and any such violation shall be punishable by imprisonment for not less than ninety days nor more than two years, or by a fine of not less than five hundred dollars nor more than two thousand dollars, or by both such fine and imprisonment.

§7. Paragraphs (d) and (e) of subdivision three of section 65.00 of the penal law, paragraph (d) thereof having been amended by chapter six hundred seventy-six of the laws of nineteen hundred seventy-three, paragraph (e) thereof having been added by chapter six hundred seventy-six of the laws of nineteen hundred seventy-three, are hereby amended to read, respectively, as follows:

(d) Except as provided in [paragraph] paragraphs (e) and (f), for an unclassified misdemeanor, the period of probation shall be three years if the authorized sentence of imprisonment is in excess of three months, otherwise the period of probation shall be one year; [and]

(e) For a class B misdemeanor, or for an unclassified misdemeanor where the authorized sentence of imprisonment is not in excess of three months, if the defendant has been found to be a narcotic addict pursuant to section 81.21 of the mental hygiene law, the period of probation shall be three years [.]; and

§8. Subdivision three of section 65.00 of such law, such subdivision having been separately amended by chapters six hundred seventy-six and ten hundred fifty-one of the laws of nineteen hundred seventy-three, is hereby amended by adding thereto a new paragraph, to be paragraph (f), to read as follows:

(f) For an unclassified misdemeanor, where the sentence of probation is imposed pursuant to paragraphs a or b of subdivision five of section eleven hundred ninety-two of the vehicle and traffic law, the period of probation shall terminate upon satisfaction of the conditions thereof.

§9. Paragraph (a) of subdivision one of section 65.05 of such law, such subdivision having been added by chapter two hundred seventy-seven of the laws of nineteen hundred seventy-three, is hereby amended to read as follows:

are eligible, very little has yet been accomplished.

CONCLUSIONS

The Commission finds that the continuum to failure, which lowers the self-esteem of young people, and ultimately causes them to be unemployable and to engage in a variety of modes of destructive and self-destructive conduct, including substance abuse, begins with a variety of conditions, the effects of which can be effectively arrested and remedied in the school system. Four techniques appear to hold the greatest promise in this regard:

First, we find that the learning process can often be aided by scaling the educational unit down to a manageable size. The proviso we offer, however, is that improving the scholastic achievement of the individual student must be the goal, rather than stimulation of interest and increased contact with staff, without specific attempts to develop increased academic skills.

Second, we find that health screening, particularly with regard to conditions directly affecting learning, such as perception, should be available to all students, regardless of income. Actual treatment of diagnosed conditions should be provided on the basis of need; however, detection of learning impediments is so often overlooked by parents and teachers, even with regard to middle-class and near-indigent children, that these services should simply be available to all in the same way that public education, itself, is available to all. We see little purpose in demanding that the state teach children to read, write and calculate, when hundreds of thousands of them are unable to do as well as their natural endowments would permit, because of learning disabilities, short of gross handicaps, that go undetected until the child becomes involved in a serious behavioral difficulty. We strongly urge the implementation of the screening techniques used by the N.Y.U. Learning Disorders Unit at P.S. 116 throughout the state, and, to the extent practicable, within the framework of community provision of health care, we support school-based diagnosis under the early and periodic screening of children program.

Third, we find that the key to continuing good health practices among school-age children, the essence and core of their respect for the integrity of their own physical well-being, and a substantial preventive to substance abuse, is the availability of competent school-nurse teachers, health aides and assistants in the schools and as liaisons between school, home and providers of community health care. We find a severe lack of such personnel and, therefore, we recommend substantial increases in their numbers.

Fourth, we find that competent guidance counselors are not free to help students and families deal with learning difficulties which result from personal problems, adjustment difficulties and unclear career choices, because of the sheer case-load burden of each counselor. We admire the efforts of the street-workers at Haaren to help students in this regard, but we believe that the state should provide more fully trained counselors in the schools, with greatly reduced caseloads. No child in the State of New York should have to take drugs or become intoxicated with alcohol in order to have attention paid to his personal or family problems.

Fifth, while we view counselor confidentiality as an incident of personal discretion, based upon the relationship between counselor and student, rather than as a legal right to be protected by statute, we also view the medical records of students as sacrosanct: In the event that greater efforts are to be made in the schools to diagnose health problems, the need for well-kept records, inviolate to discipline authorities, must be recognized.

CHAPTER IV

DELIVERY OF COMMUNITY HEALTH AND MENTAL HEALTH SERVICES

Drug abuse is one way of compensating for low self-esteem; and a child's self-esteem is based at least in part on the level of care which his family, his school and his community provide, since this demonstrates to him how much he is valued. Therefore, as part of a drug abuse prevention effort, it is necessary that all children receive proper health and mental health care. A child should never get the message that in order to receive care, he must first abuse drugs. However, this Commission finds that the problems of inaccessibility, discontinuity, and lack of follow-up which cripple the school health programs are magnified in the general community health and mental health field. The major weakness of the present system of delivery is the same as that which caused confusion about the goal of drug abuse prevention: concentration on symptoms rather than on people. Services are offered only after a problem has become an annoyance to others, i.e. the withdrawn child is not referred for help, only the acting-out child, if anyone is. Preventive care, except in the sense of public health inoculations, is rarely offered. This funding priority which stresses care in crises results, as it does in every human service field, in people suffering needlessly and services costing more than they should.

The almost tragicomic story, known to every health professional, of the mother who brings her infant, ill and running a 104-degree fever, to the well-baby clinic in her neighborhood where the child is known, only to be told "We treat well babies. Your child is sick. Take him to the pediatric clinic three miles away" exemplifies the problems created by overspecialization and fragmentation.

GAPS IN SERVICE

In 1970, Ana Dumois, Director of the Community Health Institute of New York City, listed complaints of low-income area health service consumers, as follows:

> "People do not have a single doctor they can relate to, and emergency rooms have taken the place of personal physicians.... The care in hospital clinics and health centers is often undignified, and there are long waits, discouraging people from getting even the health care that is available.... Clinics are in a sense worse than emergency rooms because the care is fragmented.... Clinic hours and procedures are arranged for the convenience of the staff, rather than the needs of the patient.... Record keeping is poor, resulting in even longer waiting time for patients and repeated tests because records are either lost or non-existent.... Patients are not told what's wrong with them, leaving them with a sense of insecurity.... Prescriptions are given, but the patient is not told what they are for, and very slow service in the pharmacy results in one more obstacle to health care.... There is no division in the clinics between those who come for minor ailments and those who are seriously ill.... There is a lack of preventive health services.... There are few full-time physicians in clinics.... There are widespread complaints about inadequate ambulance service.... Patient records are not transferred when they go from one facility to another.... The patients cannot distinguish one person from another: Who is a nurse? Who is a medical student? Who is a physician?.... Clinic patients are demoralized when they see private patients getting better treatment."*

Shortly thereafter, the Mayor's Organizational Task Force adopted the proposals of its Problem Areas and Priorities Committee with the following preamble:

> "Although this country spends proportionately more on health than any country in the world, we are confronted with major inadequacies in our health care organization and

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*Health Planning, publication of the Mayor's Organizational Task Force for Comprehensive Health Planning, October - November, 1970.

delivery system. [New York City] is in an odd position. We have the greatest concentration of superior medical technology in the world and although some shortages exist, in the aggregate we have an enormous concentration of professional personnel. New York City also has...by far the largest system of public medical care in the country.

"Adequate preventive, therapeutic, and rehabilitative care is not available to many of our citizens at levels of day-to-day community practice, either through care at home or in institutions. It is our firm conviction that whenever possible people should receive health care outside of an institutional setting. Large numbers of people - the poor, the aged, the isolated, the non-white - receive few of the benefits of modern medicine even though because of poor health they generally require more care than do more privileged groups. Middle income groups in our city also are affected by a disjointed and inadequate health care delivery system. The environment of our city - its air, water, cleanliness and health aspects of housing - is a vital part of comprehensive planning for health. It is essential that we place a high priority on the environment in which we live and on personal health services....

"Ambulatory health services are frequently crisis-oriented, discontinuous and non-comprehensive.... In a well-organized system of health care, every individual should relate to a health professional who has access to the individual's past history and who can develop a personal relationship with him....

"Another vital component of high quality medical care is a periodic health inventory for every citizen. Such an inventory will show up previously undetected disease through laboratory tests, physical examination, and by taking a thorough history....

""The health inventory could succeed only if it is supported by a program of health education which would persuade people to make use of the health opportunities available to them. Medically indigent people are accustomed to crisis medical care, and must be taught the value of preventive health examinations for themselves and their children."*

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*Health Planning, publication of the Mayor's Organizational Task Force for Comprehensive Health Planning, October - November, 1970.

The Task Force published examples of the results of lack of coordination:

> "In one area, the district health center, the pediatric clinic of the local voluntary hospital, the local Head Start group, and the school health service, each plan a drive for immunization of children against German measles. At no point do any of these agencies get together. The result: some children get their shots 2 or 3 times - some not at all.
>
> "Two neighboring hospitals each set up expensive units for treatment of patients with chronic kidney disease - at no time consulting each other. Meanwhile, neither hospital provides adequate emergency room or clinic care for local residents in the area they serve.
>
> "A comprehensive child care center refers one of its patients to the mental health center located across the street. But the pediatric center and the mental health center each serve different geographic areas, and the child is forced to travel several miles to the unit that serves his area."*

What these gaps in services mean to children is reflected in the following data on physical defects of children admitted for care at the Mission of the Immaculate Virgin, a residence for children requiring placement away from their own homes:

> "The proportion of children found on intake physical examination to have untreated medical problems the first six months of 1973 was high.
>
> "There were 99 boys and 35 girls admitted from January to June. Physical defects noted were as follows:

Umbilical hernia	5
Systolic murmurs	5
Parasitic infestations	7
Sickle Cell Trait or Disease	8
G.U. Problems	
Undescended Testicles	4
Phimosis	5
Varicocele	1

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*Health Planning, op. cit. Aug. 1970

Diminished hearing	8
Strabismus	5
Orthodontic	8
Severe Obesity	3
TB Contacts	12
Prosthetic eye (not replaced in 8 years)	1
Foot problems	6
Orthopedic Problems	
Scoliosis	1
Kyphosis	1
Osgood Schlatters	6
Poor Visual Acuity (no glasses)	15
Hypertension	1
Carious teeth	1
Enlarged Tonsils	15
Speech Impediments	12" *

All of these conditions, with the exception of sickle cell trait, are treatable. All of them affect a child's capacity to function in school. The obvious school handicaps of diminished hearing and poor vision are already statutorily intended to be checked in school. The child with the prosthetic eye which had not been replaced in 8 years, despite probable changes in the size of eye socket, certainly was known to a health service provider. One wonders how it could have happened that there had been no follow-up. Failure to bring a child for health care may not always indicate purposeful neglect, by a family. It can indicate ignorance as to the necessity for such care, not understanding that the care can really make a difference, can help; failure to understand that

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*Fogarty, Rev. Msgr. Edmund F., Director, Mission of the Immaculate Virgin, Mt. Loretto, Staten Island, N. Y., Letter of 9/20/73.

lack of care can hurt. Such misunderstanding can be clarified by staff of a health service agency, on a home visit, and this is a job which a paraprofessional can do admirably. Where there is true neglect, it may be necessary for a health service staff person to himself bring the child for the required service. These services are not frills. They are essentials.

In the area of mental health services for children, the picture is equally bleak. There is not one mental health service for children in the Williamsbridge catchment area of the Bronx, and the only single such service in the entire Northeast Bronx is Bronx State Hospital.* The Bureau of Child Guidance, which theoretically picks up those children identified by school personnel as in need of mental health care, has 5-1/2 part-time psychologists serving the 50,000 children in the school district of the Northeast Bronx. They confine their service to testing and diagnosis. But suppose a child needs treatment? The waiting list for the voluntary agencies providing such care is three to six months.** Those children who do get referred to Bureau of Child Guidance are the unruly ones or those with bizarre behavior. The children who are withdrawn, the family facing a temporary crisis, the family which has many strengths but is slightly disorganized and perhaps scapegoating a youngster, these are not even counted among the statistics of families awaiting care. They are lost. There is an almost wistful comment on this situation in a letter dated October 18, 1973, from a Board of Education high official:

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*Interview; Sister Anne, Director, Astor Home for Children, 2/25/74.

**Ibid.

> "It seems to me that staff should be made available in every elementary school to whom troubled children could be referred for intensive analysis and assistance."*

The quality of care provided the middle class depends largely on the patient's own sophistication in medical matters. The wealthier find they must move from specialist to specialist, rarely receiving the thorough comprehensive examination and testing which might reveal underlying causes for a variety of symptoms. The middle class is unable to pay for extensive private specialists, is unable to find old fashioned "family doctors," or generalists, and is unable to obtain reimbursement, under many health plans for diagnostic work or for preventive care, such as periodic annual examinations. New York State's own health plan for state employees does not reimburse for such periodic evaluations.

The extent of the longing for medical care by one doctor who personally knows the patient, in other words, for continuity of service, is hinted at in a study conducted by the Medical College of Georgia in Augusta, which revealed large numbers of city dwellers traveling up to fifty miles to practitioners in small towns, for their medical care. A study of the patient group of

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*Polatnick, Samuel, Executive Director, High School Division, New York Board of Education.

119 rural doctors revealed that 10% of their patients came from cities, although each doctor practiced in one of 26 towns studied, each of which was at least 25 miles from the next nearest town, with some doctors servicing a patient group in which as many as 20% came from the city. The doctors suggested that urbanites might be seeking to avoid the "ping pong system of medical care" in which patients bounce from one specialist to another in an uncoordinated, haphazard manner. While large cities have a plentiful supply of specialist services, the doctors said, they do have a serious shortage of the basic, broader medical services that are most frequently needed by all groups of people.* The researchers contend the same trend has affected eastern New York State, as well as elsewhere.

The Commission received numerous comments, in response to its letters of inquiry, regarding the dearth of good medical care and the connection between this lack and the prevalence of drug abuse. Captain Lorraine D. Kuhl, Director, Salvation Army, wrote:

> "Within the context of drug abuse prevention - preventive medicine means provision and utilization of medical care from infancy, as well as provision and utilization of therapy for parents and, if necessary, for the family constellation. Observations indicate huge gaps in both medical care and psychological care of residents - with untreated problems in every category from physical to psychological....

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*New York Times, Feb. 18, 1974, p. 15. Report of study by Dr. Glen E. Garrison, Dr. Warren H. Gullen, and Connie M. Connell.

> Tremendous educational impairments regarding basic reading and math."*

Professor Charlotte Muller offered suggestions regarding adolescent medicine:

> "In addition to indirect prevention of drug abuse, health services that are appropriate for young people need to be developed. Adolescents should feel that a program cares about their total health and well-being and respects them as individuals. We have studies that show the state of health in the teen years and the feelings of young people about their health. Programs should be based on such studies and should involve the youth continually in evolving the specific range of the services, the schedule, and the style and atmosphere of service.... Training, employment and other service referrals should be offered and the users of health services should be surveyed to find out what other services are needed.
>
> "It is discouraging to see punishment and threats used again and again after so many showings of failure to break addiction. In fact, it seems that the punitive approach worsens drug epidemics and raises the direct and indirect costs of drug-taking. We need more research in methods of treatment that are non-institutional and fairly compatible with ordinary living."**

SOME MODEL PROGRAMS

I. Adolescent Medicine:

There have developed a number of innovative programs which aim to offer teenagers a comprehensive service, to aid in whatever difficulties each sees as his problems. These programs are usually walk-in storefront types, and include remedial education, counseling, both individual and group, and a gamut of medical services.

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* Kuhl, Captain Lorraine D., Director, Women's Narcotic Treatment Center, The Salvation Army (N.Y.C.), letter, October 27, 1973.

**Muller, Charlotte, Professor, Center for Social Research, Graduate Center, City University of New York, letter, September 4, 1973.

There are in New York City two "Free Clinics," which are walk-in clinics providing a multiplicity of services to the 16 - 25-year-olds. One is The Door, at 12 East 12th Street, funded by the National Institute of Mental Health and headed by Drs. Lorraine Hendricks and James Turansky. They are open 6-10 p.m., Tuesday through Thursday, and offer medical care plus legal and educational services, vocational guidance, group therapy, dramatics.

They use their medical care as a means of gaining entry to explore all problems the patient may have, with a view to intervening, where necessary, in his life-style. For instance, should a patient come in with a medical problem, he is asked what he is doing, in general. If it turns out that he has been unable to find a job, he is referred for vocational guidance. If his problem is legal, such as pending eviction or criminal prosecution, he is referred for legal services by an attorney or a supervised law student.

Many of this age group would never think of going to a lawyer and might not know where to turn for vocational help, or would be put off by a large bureaucratic set-up.

The second free clinic is the St. Mark's Free Clinic, on St. Mark's Place.

There are also a small number of Adolescent Medicine Services in hospitals.

In New York City and environs, there are ten Adolescent Medicine Services, but only four are full-time and deal with the total patient. These are: Montefiore, Roosevelt, Mount Sinai, and Long Island Jewish Hospitals (this last is in Nassau).

There are less comprehensive services at Bronx-Lebanon, New York Hospital, Beth Israel, and Bellevue. In addition, St. Vincent's and Brooklyn Jewish have a clinic operating one or two afternoons a week.

In the area adjacent to Montefiore Hospital, in the Northeast Bronx, there are 16,000 adolescents in school (Lehman College, Bronx High School of Science, Evander Childs High School, and two others). The only Adolescent Medicine Service in the area is that of Montefiore Hospital, with 32 beds. Montefiore offered to pub a medical teacm "on site" in a school. The Board of Education said they had no funds for this. The City Department of Health said it was short of funds.*

Adolescent medicine as a specialty is only about ten years old, and came into being with the loss of the general practitioner. There are a number of medical problems particularly prevalent among adolescents. The old-fashioned general practitioner became familiar with them in the course of his general practice.

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*Interview with Dr. Iris Litt and Dr. Cohen, Montefiore Hospital Adolescent Service, July 6, 1973.

Today's specialists often do not. When "family doctors" were available, they would treat a person from cradle to grave, drawing on their personal knowledge of a family to help effectively, and often had the trust of the teenage family members. With the diminishing number of these general practitioners, at least in urban centers, the situation has changed. Pediatricians see children up to a given age, usually 13 or 14, and then stop. The family tends to go to an internal medicine specialist for check-ups, or to other specialists, and the child, when he reaches the pediatricians' cut-off age, is dealt with as an adult. Likewise, hospital clinics are set up the same way: a pediatric clinic, then a medical clinic and specialty clinics.

There is as yet no cadre of doctors trained in adolescent medicine in this country. In New York State there is not one publicly-funded training program. There are a few privately-funded ones.

Nationally, there are four federally-funded slots for training physicians, and 21 privately-funded ones.*

Commission staff met with Iris Litt, M.D., and her associate, Dr. Cohen, at Montefior Hospital Adolescent Service.

Drs. Litt and Cohen view an adolescent medicine service as an excellent door to intervene in the teenage patient's life-style, where necessary; and thereby to prevent drug abuse or ending drug experimentation, in addition to other social and medical problems.

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*Ibid.

They see Adolescent Medicine as the best way of reaching teenagers because physicians have not yet used up their "credit cards" with young people. Many of the other "helping" professions have. Montefiore did a survey recently in which they asked 16-25 year olds to whom they would go if they were in trouble (teacher, parent, peer, minister, doctor, social worker, et al). "Doctor" rated very high on the list.

Montefiore's Adolescent Medicine Division is geared to the "total person" approach to medicine. They find their young patients come to them only when they are in real pain or discomfort. Once there, and having received physical relief, they are open to discussions of other problems, and are referred to social service for a great deal of direct help and for referral to other agencies, with follow-up.

Often, the presenting problem turns out to be not the most basic problem. For whatever reason a patient is referred, once there, other problems are discovered and treated. For example, a patient referred by his family for marihuana smoking, which they considered to be the presenting symptom, was found to be psychotic and treated for that.

Another patient, referred for other symptoms, may be found to have a drug problem, and this is dealt with along with the rest of his medical problems.

One example of the kinds of social help offered by the service is as follows:

A child who has dropped out of one high school but would like to go to another one, perhaps with a specially-tailored program, would never think of approaching the school himself. Social services will arrange for this sort of thing.

Drs. Litt and Cohen outlined the following problems they considered subject to legislative remedy:

1) There is no central agency responsible for adolescent medicine. In the City Department of Health, statistics on teenagers are lumped in with Maternal and Child Care. It is impossible to get data on this group from insurance companies, because they are always covered under a family plan, with no specific age differentiation.

There should be a central agency to collect and hold data on medical problems of adolescents and also to be the responsible body to whom medical practitioners can bring their problems.

2) Legislative provision for an adolescent to receive medical care without parental permission, in certain instances, has not accomplished its purpose, because the teenager cannot pay for his care without going to his parents. It should be possible to provide each under-age member of a family with his own medicaid card, or private insurance card, since he is covered anyway under the family plan.

3) Training programs for physicians must be funded.

II. The Astor Home:

One voluntary agency which succeeded, where Montefiore Hospital failed, in establishing a connection with the Board of Education, is the Astor Home. The funding for their project was initiated by private foundation, although eventually state reimbursement for service will be available.* About one year ago, Astor Home, which operates residential treatment centers for children, some of whom attend local public schools, offered a service to P .S. 21, in the Bronx, as a pilot project to identify mental health needs of that area. They offer skilled and trained consultation to the teachers in that school in how to cope with and help students who are presenting problems. It quickly became clear that some of these pupils and their families should be referred to a child guidance clinic. There being none available in the Northeast Bronx, Astor Home developed one. They have been offering child guidance counseling to everyone who applied for it, and because they are so new and unknown as yet, they do not yet have a waiting list. It is their hope to obtain sufficient staff to continue to avoid such a list. They have been in the process of obtaining state certification since October, 1973, most of the problems they encountered being centered on the physical plant of their clinic. Required renovations were completed in January, 1974. They have involved Misericordia Hospital Adult Psychiatric Service to cooperate in the consultation service offered the teachers at P.S. 21, and Misericordia accepts the adult members of the family of any pupil who requires their service

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*Interview with Sister Anne, Director, Astor Home, Feb. 25, 1974.

Additionally, they have enlisted the cooperation of the pediatric service of Misericordia Hospital, to provide the health care the children need.

Sister Anne, Director of Astor Home, expects to draw in the Visiting Nurse Service, to provide health care at home, and follow-up care, where needed. She indicated there was urgent need for staff intervention to help many of the families find suitable housing, because their living conditions were exacerbating problems, or because they were in a housing crisis, such as eviction. They do not have sufficient staff to provide this service, but she considered it probably inevitable that they eventually do so.

They are also expanding their teacher consultation service to three parochial schools in the neighborhood, in the hope of also being of service to those families whose problems are not necessarily financial but who still cannot afford expensive private professional services.

COMPREHENSIVE HEALTH CARE

The Partnership for Health Law, passed by Congress in 1970, calls for the development of Comprehensive Health Planning

Agencies in each state, and the development of Health Maintenance Organizations. Edward H. Van Ness, Executive Director of the New York State Health Planning Commission, described a Health Maintenance Organization as "any program for delivery of health care with the exception of solo practice on a fee-for-service basis. Essentially, in an HMO, the emphasis is on preventive medicine." He continued:

> "An HMO is a pre-paid health care system that provides its members with periodic screening and a check-up to detect disorders before they make people sick. All of us have found that it costs a lot less to keep a person well, than it costs to make him well after he's become ill. An HMO provides or arranges for all ambulatory or in-patient health care services, and assures effective continuity of care. There are HMO's of various kinds already operating throughout the country."*

New York City's Health Insurance Program is one such Health Maintenance Organization.

In 1970, New York City's Office of the Mayor established the Mayor's Organizational Task Force, which eventually became the Comprehensive Health Planning Agency of the City of New York. That Agency, in its grant application of March 31, 1971, describes its goals as follows:

> "Our priorities are in terms of the individual and his family rather than disease categories. They derive from broad-based problems, whose solutions will affect changes in health delivery.
>
> "The goal of the work program is the development, in the community, of an integrated system of planning for environ-

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*Van Ness, Edward H., Executive Director, New York State Health Planning Commission, in an interview published in Health Planning, op. cit. March/April 1971.

mental and personal health care which will have the following components:

1. Establishment of CHP Districts and District Boards so that the various communities of our city can participate in comprehensive health planning.

2. An environmental setting (including land-use, safe and adequate housing and transportation, clean air and clean water) within which our citizens can enjoy life.

3. A process whereby individuals and families entering the health care system can relate to a primary physician or health professional who is a member of a health team. The health team will provide basic preventive, diagnostic, therapeutic, and rehabilitative care. The health team will also coordinate and supervise appropriate referrals to other health-related specialty services for both ambulatory and in-patient care.

4. A system for the collection of health data.

5. Neighborhood health centers, institutional-based out-patient departments, and group and solo practitioners of medicine which will be incorporated into the system and included in a coordinated network of communication.

6. Health services which will be available, on the same high quality basis, to individuals of every socio-economic level. The individual can choose for himself the type of entry into the system he prefers: neighborhood health center, a community based group health practice, an institutional based group, or a solo practitioner.

7. Mental health and mental retardation services, school health services, home health services, and environmental health services which will become part of the coordinated system, so that separate programs for diagnosis of lead poisoning, rubella immunization, or establishment of methadone clinics will be unnecessary.

8. Examination of methods of financing medical and dental care so that the Agency - to the extent it has power or influence to do so - can ensure that every individual, with his family, is protected against illness, and is covered for ambulatory, inpatient, and home health services. This will include basic medical care in all the major areas, as well as ancillary services such as nursing and social service. The Agency will also examine the financing of environmental health services, and will make recommendations upon this subject.

9. Regular dissemination of information about planning for environmental and personal health services, which will be an important component of all the work programs.

10. Training of consumers and providers in methods of comprehensive health planning and program content of the work programs, which will be a continuing responsibility of the Agency.

"The Agency will attempt to build into the system ongoing evaluation of the quality of medical care provided, of satisfaction with personal and environmental health services, and of appropriate and effective utilization of professional personnel. It will also attempt to develop a plan for ongoing evaluation of environmental health."*

Their statement on continuity of health care deserves special attention.

"Ambulatory care includes office services of private practitioners of medicine and dentistry, hospital-based outpatient clinics and emergency rooms, neighborhood health centers, union health centers, and pre-payment group health programs. Ambulatory health services are frequently crisis-oriented, discontinuous and non-comprehensive. Patient amenities are frequently disregarded; records of previous visits are not available; and the patient may be seen by a different physician, nurse or social worker at each visit. In a well-organized system of health care, every individual should relate to a health professional who has access to the individual's past history and who can develop a personal relationship with him.

"The point of entry into the health care system should be contact with a physician who will perform a complete medical evaluation of the individual with appropriate diagnostic procedures.

"Ongoing surveillance and maintenance of a personal relationship with the individual and his family may be delegated to the health professionals other than the physician; e.g., a health team, a nurse clinician, a patient advocate and other professionals and para-professionals. This method of delivery of health care functions well if a physician is readily available for consultation and if the health professional or para-professional has been taught when to call for the medical expert. The utilization of nurse clinicians for routine well baby care in Denver, the ongoing care of cardiac patients by well-trained physician's assistants, has been described.

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*Grant application, Comprehensive Health Planning Agency of the City of New York, Vol. II, March 31, 1971, pp. D-2 and D-3.

"As a part of the study of the delivery of ambulatory care, we might investigate reasons for the lack of continuity of patient care in our existing facilities and develop a system which will ensure every individual and family a personal physician at the point of entry into the health delivery systems with surveillance by a physician or health professional assigned to the patient with whom the patient can arrange an appointment for each successive visit. Assurance of continuity of medical care for the individual patient is the critical factor in the delivery of high quality medical care. Continuity of care means assumption of responsibility by a physician or health professional to whom the patient relates. This method will ensure the following:

1. Knowledge of past episodes of illness, previous diagnostic procedures and therapy;
2. Adequate history, physical examination and medical evaluation;
3. Availability of appropriate diagnostic tests and evaluation of the results;
4. Institution of immediate treatment and a plan of care;
5. Referral to appropriate medical, nursing and social agencies;
6. Maintenance of preventive health care;
7. Care of concomitant socio-economic and emotional problems.

"This type of care can only be given when a single health professional or a health team maintains an ongoing personal relationship with the individual patient. This can be done in a variety of ways, provided there is immediate availability of a physician when necessary.

"In order to achieve this goal, an ambulatory care facility must have the following organizational structure:

1. an appointment system;

2. full-time or part-time professional staff rather than a rotation system; e.g., physicians and nurses who rotate through outpatient department at 3-month intervals;

3. a unit record system, in which laboratory and X-ray reports are readily accessible and available;

4. an adequate number of general medical, pediatric and dental clinics in operation at hours convenient to the patients and which provide diagnostic, therapeutic and preventive care;

5. availability of appropriate back-up specialty services and diagnostic facilities;

6. 24-hour telephone service manned by a health professional so that advice and reassurance can be given and immediate decisions made.

"The concept of the 'open hospital,' for both municipal and voluntary hospitals - that is a hospital in which every physician, licensed by New York State, can admit and treat patients, should be investigated.

"Quality of medical care can be maintained in an 'open hospital' by public regulation of surgical and specialized medical procedures for physicians qualified in the specialty and by stringent regulations about medical consultations; e.g., an infant cannot be discharged from the nursery without a complete examination by a pediatrician. An 'open hospital' provides continuity of care for the patient and can be a factor in doing away with the double standard of medical care - patients admitted to a ward service who do not have a personal physician and are cared for by the 'house staff' under supervision of the attending on service.

"Increased emphasis should be placed on encouraging generalists in community medicine practice, and teaching in medical schools and hospital programs which emphasizes the concept that the primary purpose of medicine is patient care and that medicine is a service profession."*

On the state level, a bill introduced by the Standing Committee on Health of the Assembly, which has acknowledged the need for prepaid comprehensive health services plans, stated the legislative intent of encouraging the expansion of health care options, and provided for state certification of such services in a proposed law. The bill* introduced would supplant Article 44 of the Public Health Law, which provides for the creation of non-profit medical corporations, and would provide instead for the operation of comprehensive health service plans.

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*Ibid, attachment 8-1 and 8-2.

The bill defines a comprehensive health service plan as a "plan in which each member of an enrolled population is entitled to receive comprehensive health services in consideration for a basic advance or periodic charge."

It defines comprehensive health services as "all those health services which an enrolled population, defined as to its probable age, sex and family composition, might require in order to be maintained in good health, and shall include, at least, physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, home health services and preventive emergency and health services. Such term may be further defined by such regulations as the commissioner shall deem necessary, desirable or appropriate to meet the health care needs of a population."

The bill contains the following statement of policy and purposes:

> "§4400. Statement of policy and purposes. Improving the present method of delivering health care services is a

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*Assembly intro. #9232, introduced by Mr. Hardt, Feb. 4, 1974, pp. 2 and 3.

> matter of vital state concern. Without improving the present system, increased health insurance and other benefits will continue to escalate the cost of medical care and overload the delivery system. Prepaid comprehensive health care plans, wherein members of an enrolled population are each entitled to receive comprehensive health services for an advance or periodic charge, represent promising systems for delivering a full range of health care services at a reasonable cost.
>
> "Accordingly, it shall be the policy of this state to expand the health care options available to the consumer and insure that he will have freedom of choice in choosing that plan which is most compatible with his needs."

The urgent need to reform health services delivery is reflected in the fact that Congress is currently considering six major legislative proposals for health care. These include the Kennedy-Griffiths-Corman bill, entitled "The Health Security Act", a single-track program which would provide a Health Security Trust Fund, of monies from general taxation and from additional social security taxes; the Long-Ribicoff proposal, entitled "Catastrophic Health Insurance and Medical Assistance Reform Act of 1973", which purports to provide catastrophic insurance for virtually every American, an extended medicaid type coverage for low income families, and "a new and voluntary federal certification program for private health insurance policies", based on the assumption that if the government accepts responsibility for the highest risks, in the first two parts, "the voluntary insurance industry could reasonably be expected to meet the challenge of adequate basic health insurance for the remainder of the population."* A third major proposal is the Administration Plan for National Health Insurance, also a two-track program, with a Standard Employer Plan, which would require private employers to offer to their employees a minimum package of benefits and pay 75% of the premium cost, and a Government Assurance Program, to replace Medicaid, under which private health insurance carriers would contract to cover low income persons, using federal funds to cover or subsidize costs, and cost-sharing by the insuree dependent on income.

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*Fulton, Tom, ACSW, "Federal Legislative Proposals for Health Care," The Advocate for Human Services, published by the National Association of Social Workers, Washington, D.C., Vol. 2, No. 23, December 15, 1973 and Volume 2, No 24, December 31, 1973.

Whatever plans are eventually accepted, this Commission recommends that health and mental health services be made available in residential communities of all income-level housing, in one building or a contiguous complex, and that these services guarantee continuity of care, with adequate and vigorous follow-up to ensure that medical recommendations are understood and accepted by the patient and his family.

We recommend that services be organized in such a way that they serve the needs of people, rather than those of medical specialties, or administrators, or other considerations.

We further recommend that health and mental health facilities, both public and private, be available to all schools, either as offered by Montefiore Hospital's Adolescent Service, or through back-up services and consultation, as in the Astor Home-Misericordia Hospital Model. Schools, after all, are the one agency through which every one of our children passes.

CHAPTER V

THE FAMILY

Children live in families and families live in communities. Therefore, if we are to provide that gamut of options we consider to be genuine drug abuse prevention, we must look to the setting from which most children receive, or fail to receive, succor.

Many of the professionals who responded to the Commission letter of inquiry regarding their views on prevention of drug abuse stressed family breakdown, and value vacuum, as causations of drug abuse.

THE FAMILY AND DRUG ABUSE PREVENTION

Of the need for nurturing, Ruth Sullivan, ACSW, Casework Supervisor, Family and Children's Service of Albany, wrote to the Commission, dated October 9, 1973, "...based on my many years of experience of counseling with people - of many age levels, varieties of economic and social achievements, racial and ethnic backgrounds, and a wide range of personality deficits - I am brought again and again to the significance of the quality of emotional nurturing, so often lacking (in one degree of another) in people's childhood experiences. Also, so much of people's current behavior (constructive and destructive) has the underlying motivation of remastering or undoing earlier deprivation and/or unfulfilled longings. The regressive symptoms and effects, resulting from drugs and alcohol dependence, are another indication of this same infantile struggle.

"Mainly, I wish I knew of some effective way of helping people to be more comfortable with their conflicting feelings and fears - to help them realize we all experience the same emotional tensions and pressures, at one time or another and with varying degrees of intensity. Education and group discussions at critical stages; marriage, pregnancies, school years, adolescence,need to be implemented..."

Norman A. Cosentino, Head Counselor, Educational Society for the Prevention of Adolescent Drug Abuse (ESPADA), wrote, August 15th, "Most drug related problems come about due to family instability. The person then adjusts his lifestyle to compensate for the lack of affection attention and the great amount of pain he feels. It is this 'negative' lifestyle that can lead the individual to drug abuse."

Thomas A. DeStefano, Director, Catholic Charities, Diocese of Brooklyn, put it this way, (August 29, 1973) "While we have found training for staff with regard to drugs is important, we feel the more successful approaches are two-fold:

1. Humanizing the youths' immediate reality - whether that be foster care or family.

2. Creating meaningful options in the lives of youth."

And Louis A. Patrizio, M.D., Commissioner of Mental Health, Oneida County, wrote on September 10, 1973:

"First of all, family breakdown and dysfunction are in part responsible. If a child is raised in a home environment that leads him to believe that he is loved, accepted, and has value in himself, then there is a strong possibility that he will not turn to drugs.

Conversely, if his family does not know how to reasonably solve its internal and external problems, if it scapegoats the child, leaves him with feelings of worthlessness, then he may turn to drugs as an escape, to relieve anxiety or to gain acceptance from peers.

"With regard to the societal component, I believe that many families that are poorly equipped psychologically, often succumb more easily to economic pressures. For example, if the head of a household suddenly becomes unemployed and is unable to find a comparable job, then undue stress may be placed on the family and give rise to internal conflicts.

"Lastly, it is the responsibility of the society to provide services to families to prevent breakdown or restore harmony."

Irving Rabinow, Associate Executive Director, Jewish Child Care Association of New York, added the thought, in his letter of August 22, 1973: "There is a need for comprehensive supportive services to families of these (disadvantaged) children to avoid family disintegration, meaningful employment for adults which adds to parents' sense of self-worth, and educational and vocational training opportunities for youth...The latter is particularly important because the highest incidences of drug abuse and drug dependency is among the 16-18 group...These preventive goals seem to be within the possibility of achievement if our society is willing to provide the leadership and funding for such programs."

THE EMBATTLED FAMILY

It is relevant to review some of the conditions which place stress on the urban and suburban families in which children live - those children who abuse drugs and those who do not—and to evaluate how our present system of societal support for these families succeeds.

If we want to cure those who are abusing drugs, and to prevent those who have not begun to turn to drugs from doing so, it is time to care about drug users and non-users: to care about children and about the families and communities they need if they are to have a means of coping and of enjoying that is not chemically induced. To cure stems from the Latin curare which means to care.

New York State, like the rest of the nation, has characteristics which are unique and which affect the ways in which families function and children feel they "belong" or do not, they can achieve, or cannot, they are worthwhile, or are not.

These include the rich diversity of our population, but also the extent to which our population is organized, geographically and socially, into distinct ethnic groupings, each of which feels strange, and estranged from the others. This estrangement leads to fear, and to tension, and diverts the members of a community from identifying the source of their neighborhoods' problems and working cooperatively to solve them.

Another characteristic which shapes the milieu in which New York children grow is our tradition of upward mobility, which stresses creativity and individual achievement, rather than teamwork. The Horatio Alger tradition, when counterposed against the reality of slum life, is confusing. Supposedly, everyone who can "cut the mustard" can be a success. This philosophy is a spur to those gifted children from well functioning families who work together to help the child move up the ladder. But for most slum children, the way up is so booby-trapped by poor schooling and family stress that the legend serves only to highlight what seems to them hypocrisy, or it is realized through the channel of organized crime.

Geographic mobility, encouraged by the pattern of the worker following his job and the executive being transferred, and by the fact that housing is allowed to deteriorate, so that many are forced to forever "move on", makes it more difficult to engender that sense of neighborliness which helps sustain a family.

The absence of an extended family, to support the nuclear family (parents and children) makes social problems of situations which used to be coped with by the family in the course of daily living. A mother taken ill in the middle of the night, who has an aunt or cousin down the road or down the block to come over and care for sleeping children while she and her husband go to the hospital, has a medical problem, but not a social upheaval. Such a mother, without the closeness of relatives, but with roots in her neighborhood, can at least make do with friends or neighbors. But what of the family new to the community, isolated, or in a neighborhood where families live in such overcrowded conditions that there is no room next door to carry in sleeping children and put them to bed until morning.

The stresses such an isolated family feels are magnified when both parents are working or when there is a single parent. There are in New York, as of the 1970 census, 508,474 such families.* The stresses are further compounded when the family lives in poverty.

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*U.S. Census, 1970.

THE FAMILY AND POVERTY

In its March, 1968 report, the Joint Legislative Committee on Child Care Needs wrote:

"To not have enough money creates pressures which shatter a family, demoralize and debilitate a parent, trap a child so that when he reaches adulthood he is able only to perpetuate the cycle....

"Families disintegrate from the sheer stress of trying to support themselves on an income that cannot cover their basic needs."

The 1970 census reported 17.3% of the 2,044,000 families with children in New York City had a single head of household who was female, or 354,000 families. Among Blacks, the figure rose to 32.8%.

The 1968 committee report explained the high percentage of broken families in Black ghettos as follows:

"When families come to New York together from rural areas, the very pressures of urban living cause disintegration of family structure. Here the family does not work together in the fields, the father does not come home for lunch, the children are not an economic asset. When, as happens too often, the mother finds work and the father does not, the process of his developing a sense of uselessness and worthlessness, culminating in his inability to face the situation and flight from it, begins..."

The report cites testimony before the Senate, in July, 1967, that only two out of five adult men in the Black ghettos of New York City earn at least $60 a week, and fewer than three out of five hold any job.*

"All the problems of the central city fall in upon the mother-and-children family with special impact," the report continues. "The concentration of low income population in the inner city, the fact that such a small amount of housing has been built in thirty years, the overcrowding of our schools, the shortage of jobs for unskilled workers, the scarcity of health services, the breakdown of public services such as environmental sanitation and police protection, the absence of an organized extended family such as aunts and uncles, grandparents, in a position to babysit, to help with finances, to share household chores, make the lives of these women extremely pressured...

"Because of the low level of public welfare budgets, the option to be a homemaker and raise one's children oneself, with the help of public welfare, is not a real one. Being a homemaker implies managing a budget, making choices and decisions about spending which involves one's value system and what one wants for one's children, expressing one's concepts of 'homeyness.' The current welfare payment level allows for none of this. When the money coming in covers the bare minimal essentials needed to maintain life, without a radio or TV, without a telephone, without extra carfare or movie money or money for curtains, there is no room for options. There is no homemaking..."

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*A comprehensive Blueprint for Child Welfare Services in New York State, Report of the Joint Legislative Committee on Child Care Needs, March, 1968 (Legislative document 1968, No. 8) p. 51.

"If we are to enable today's children of poverty to become part of the mainstream of American life and to become adults who contribute to that life, we must take a dual approach which gives today's mothers a genuine option. We must make it possible for those who wish to, to remain at home to really be homemakers, and we must make provisions for those who prefer to support their children by their own labor to do so while their children receive good care."

THE MIDDLE CLASS FAMILY

Families with a middle or upper class income and life-style are now living through their own crises of goals, directions, values. The old ones seem no longer to work. The children are searching for new ones. The parents are often lost. This crisis seems connected to the broadest social issues, such as the role of this nation in international affairs and the moral leadership the U.S. used to exert and seems to have lost; to the affluence and technology which have made homemaking dependent as ever on the skill and art, the sensitivity, perciptivity and tenderness of the homemaker, but no longer on her full time effort; to the emphasis on "finding oneself" which is the counter to the alienation and automatism imposed by the bigness of our social organizations. Against this backdrop, the middle class family is floundering, and feels unable to cope with the problems of their children, and therefore frightened to acknowledge that problems exist. This fright is often expressed as "permissiveness," as "wanting Johnny to know I trust him," summed up in the phrase, used for 13 and 14-

year-olds, "she knows the options and the consequences, now the choice is hers." That family members need to protect each other, that a child need not really live through all the pains of life personally, to "choose his way," is lost sight of. The mother of a 14-year-old girl, the bookshelves of the home she shares with her husband replete with the latest sociological treatises, explains she had just allowed her daughter to leave the home ostensibly for a school dance, and had agreed to a curfew later than she felt was justified by attendance at a dance, although she had an uneasy feeling that there was no dance that night, because "I want to be permissive." Why? "Because I am afraid if I am not, she will run away." This, too, is poverty.

Later, when the little girl returned, anxious and defiant after having spent the evening in the home of two 19-year-old young men, the parents did not want to know what she may have been through. They not only accepted her story ("It turned out there was no school dance tonight so we went to the movies"), but helped her lie ("maybe you tried to call us, but the line was busy"). To the child, this not wanting to know feels like not caring. It is neglect - neglect born of fear, of a sense of emptiness, of having nothing of value to give to and to hold one's child. That this child was already using alcohol and marihuana, with the parents' knowledge, and quite possibly other drugs, is almost inevitable. But it is also not the main point. The main point is the pain.

School will try to help, for the child is in trouble with herself there too. But the family has already dealt with that once by deciding the problem was that the school was too permissive, and sending her to a different private school. This mother does not work. She thinks it important, she says, to be home to "keep track of" her daughter. But even when she is there, she is not really there.* The best hope for this child is to come to the attention of someone who can know her confusion and help her. Our priorities being what they are, this is most likely to happen only when she gets into big trouble.

SERVICES TO STRENGTHEN FAMILIES

What, then, can be done?

With all of our declarations of belief in the critical importance of family in the development of a child, our society does not take family life as a value on which it is valid to spend money. Programs are never funded simply because they are good for the family. We require a secondary social goal that bears no relation to the goal of strengthening families so they can help their children to flourish. In so doing, we often miss the mark.

For instance, the goal of providing good care for children of working mothers, so popular in 1967-68, became distorted into that of getting mothers off welfare, which, in turn, meant that day care became a service to the poor, and, therefore, a poor service.

Little has changed since the report six years ago of the Joint Legislative Committee on Child Care needs. Our funding is still concentrated on those most expensive, least effective,

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*Conversations with the family, January 1974.

"after the horse is stolen" programs, which are used to prevent personal problems from becoming social nuisances, rather than on services which could strengthen families and help them cope.

Day Care:

One preventive service is quality day care, to nurture the children of parents who work or those of mothers who need some relief from 24-hour child-caring. Without diminishing the value of a close parent-child relationship, it is conceivable that in many situations the mother who, unwillingly, is with her child full time, is harassed, angry, ungiving, and that the temporary care for her child outside the home (that surcease once, but often no longer, available through the cooperation of cousins, aunts, and grandparents), would vastly improve the quality of such closeness. Similarly, the working mother whose mind is at ease about her child's care can return in the evening much better able to cope with the problems left over from the day than can the one who is tense and guilty and anxious about her child's care, and then must cope with a frazzled, possibly mistreated child.

Katherine Oettinger, former chief of the U.S. Children's Bureau, estimated in 1968 that nationwide, 38,000 children under 6 were left with no care at all while their mothers work. Many were just locked up at home. Another 70,000 were cared for by sisters and brothers often not much older than themselves. That year, a study by the Medical and Health Research Association of New York found children cared for in appalling conditions and mothers pleading for the creation of proper facilities for their children.

The 1970 census counted, in New York State, 219,074 married women with children under 6 years who worked outside the home; 128,838 women Heads of Household with children under 6 and another 100,636 with children 6 to 18 years; and 60,000 male Heads of Household with children under 18. These are the families, by and large, from whence come the latchkey children, who spend the hours between the end of school and the parent's homecoming unsupervised, often aimless and lonely, the pre-schoolers left with neighbors and unlicensed day care homes who are sometimes neglectful, sometimes even cruel. These are the families in which the 11 year old must stay home from school if the 4 year old is sick and cannot go to the caretaker down the block and the parent must work.

The Agency for Child Development, in New York City, estimates there are in the city 250,000 children under age 6 whose parent(s) are on welfare or whose mothers work and the family income is under $10,000 per year. The Agency considers all these children to be among those who would greatly benefit from skilled day care. But there are in the city 47,000 day care slots for such children. Although this is substantially above the 7,000 such slots available in 1968, it is still, according to Georgia McMurray, only 10% of the minimum needed.*

And what about those families earning more than $10,000? What are their options? Again, there is the neighbor down the block -

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*Interview with Georgia McMurray, Commissioner, Feb. 18, 1974.

and there are paid babysitters who will come to the child's home. But any working parent can attest to the mixed bag from which such assistance comes, the disruption in a child's life when the caretaker is replaced, the absence of playmates and loneliness of such children.

Day care, as originally conceived, was intended as a service to all children, regardless of income, who would benefit from an alternative to a parent's care at home.

With the first flush of enthusiasm and early federal funding, in 1967-68, many day care centers were set up to take children of all economic levels in the neighborhood, on a sliding scale fee basis.* This enabled children to mingle in a socio-economic mix, and it enabled daycare centers to supplement services they could buy with government funds. By 1972-73, official policy was moving toward tighter restrictions on who was eligible for day care, a sharp limitation on the number of fee paying participants, and a cutting off, in essence, of all those earning over $10,000 by pricing day care out of the market ($70-$80 per week per child) for those not eligible for partial reimbursement.

Because of the $1.9 million ceiling on Federal spending under Title IV A, the Agency for Child Development will receive only 50 percent Federal reimbursement for fiscal year 1973-74. Unless the ceiling is raised, the percentage of Federal money will be even lower in 1975-76.

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*The Westside Center, for example.

This means less day care for the poor, and much less day care for the children of middle class parents.

Homemakers:

Another such family-strengthening service is homemaker service, that service whereby a homemaker stays in the home, substituting for the mother, during a temporary emergency, holding the family together, instead of the children being placed in foster care, often separated from each other.

Studies have shown that where a homemaker has gone into a home and kept the children together, the parent, temporarily disabled, has recovered more quickly, has resumed the care of the children, and moved toward independence.

Where the children are placed outside the home during a crisis, the family disintegrates and the parents tend to deteriorate and to fail to resume the care of the children.

The U.S. Department of Health, Education and Welfare estimates that New York State needs 18,800 homemakers.* In 1966 there were 957. Lacking an infusion of Federal funds, the service has grown slowly.

The New York City Department of Social Services, in a pilot project in 1967, maintained 2400 children in their own homes who would otherwise have been placed, by sending homemakers to them. In most situations the homemaker cared for the children on a short term basis, during a crisis period. This gave the family time to make long term arrangements, if necessary. This small New York City experiment saved the state close to $80,000.

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*Are Services To New York's Children Effective? Report of the Joint Legislative Committee on Child Care Needs, 1966, p. 20.

The cost of homemaker service today ranges from $1.85 to $7.50 per hour,* depending on the number of children, the city in which the service is offered, and whether the homemaker sleeps in or not.

Without these services, all too often the children who would benefit from them are placed in institutions, or in one of the alternatives to large settings: agency-operated boarding homes (with a capacity for up to six children), group homes (7 to 12) and group residences (13 to 25). There are 28,000 New York City children in such placement, both public and voluntary agency sponsored, at an annual public expense of $170 million.** Foster care, the least costly, runs to $4,015 per child per year, and group homes, $12,000, and institutions $14,000. What might have been done with a fraction of that amount, spent early, before the situation deteriorated to where placement was necessary?

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* Information from Herbert Alfasso, New York State Department of Social Services, February 1974.

** Report of the City Planning Commission, cited in New York Post, Feb. 13, 1974, p. 32.

Some agencies are trying to service children and families in the neighborhood. The Wyltwick School for Boys, for instance, operates a community-based family services center in Brooklyn, which works with other agencies in the 79th precinct to coordinate services and to identify gaps in service, and operates an adolescent program of education and vocational help and a day care center for 10 to 14 year olds who either come after school or, if they are school dropouts, who stay all day and receive Board of Education accredited courses. In addition, this center trained 12 women from the neighborhood as homemakers. These women go into the homes of families who are disorganized or are in a crisis situation, instead of the children being placed, and help the family negotiate with department of social services, help them relocate, intervene with the schools, and otherwise ameliorate tensions and help the family hold itself together. The service has been functioning for over a year.

The homemakers are on an annual salary of about $8000. The human benefit derived from a service which helps a family stay together and learn to function more cohesively is matched by the fiscal savings of this service in contrast to the cost of placement. Funding, however, is chronically insecure.*

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*Interview, Wiltwyck School for Boys, Inc., Feb. 20, 1974. Jacqueline Pitt.

Self-Help Efforts:

A number of self-help modalities are being developed. The Visiting Mothers-Sereno Workshop on New York City's lower Each side, is one such. The mothers on one block formed themselves into a cooperative day-care and extended family service. Linda Cusmanno, a founding member, explained, "Sometimes a mother just falls apart - especially after her welfare worker has visited. She just can't function. We go in and take her children to our house, or stay in hers and call a doctor if she needs one, or just let her rest."* A simple formula. A service many of us take for granted. But most of the mothers living alone with their children in poverty in New York have neither the ingenuity or energy to sustain such an endeavor.

Cooperative living arrangements, in which several families share a large apartment and help each other, substituting for the extended families which they do not have, is another type of self-help. The efforts of the young, themselves, to build their own substitute families, by establishing cooperative living arrangements, or communes, is another.

Employment:

The simplest alternative to drug abuse is a job which is at least moderately satisfying and which pays a wage on which one can afford the basics one considers essential.

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* Testimony, hearing, Joint Legislative Committee on Child Care Needs, Dec. 14, 1967.

This is true for the teenager and young adult seeking employment. It is also true for the head of household seeking to provide his children with a stable home.

This Commission pointed out, in a report in January, 1973,* the counterproductivity of "spending millions of dollars on treatment with the result that millions more must be spent to keep able-bodied young people on welfare" for lack of jobs. Again, in a March, 1973 Report,** the Commission noted that "The inability to become self-supporting, frustrating the ex-addict's drive to become socially constructive, can nullify the rehabilitation process."

But the employment problems of addicts are overlaid on employment problems of a broader group. Although rehabilitated addicts do suffer special discrimination in employment, a lot of other people cannot find work either.

The U.S. 1970 census counted 6,470,450 male population over 16 in New York State, of which 4,579,774 are potentially in the labor force. It counted 6,963,022 females over 16 in New York State, of which 2,878,973 are potentially in the labor force.

It defines "not in the labor force" as "students, housewives, prisoners, disabled, aged," and seasonal workers who are not job-seeking off-season. The census does not count, as unemployed, students, "housewives," disabled, and others who may be seeking work but are not registered anywhere as unemployed because they have never been employed. Nevertheless, based on their criteria, the unemployment rate is as follows, in New York State:

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*Employing the Rehabilitated Addict, supra.

**How People Overseas Deal with Drugs, supra.

Unemployment Rates

		Total	Black	Puerto Rican
MALES	16-19 years	10.9	20.8	17
	20-24 years	6.5	9.4	8.5
	All ages 16 & up	3.6	5.6	6.1
FEMALES	16-19 years	8.7	13.9	13.1
	20-24 years	4.8	6.9	7.5
	All ages 16 & up	4.6	5.2	7.8

Each person forced into the statistical category of unemployment is a human person - an eighteen year old young man with nothing to do but "hang around," a thirty-five year old woman forced onto welfare. The deadening monotony of unemployment is expressed in a popular recording by a comedy team call Cheech y Chong,* one sequence of which involves a school teacher asking a boy in class to read his essay on "How I Spent My Summer Vacation." He says: "The first day of my vacation I woke up. Then I went downtown to look for a job. Then I hung out in front of the drug store. The second day of my summer vacation, I woke up. I went downtown to look for a job. Then I hung out in front of the drug store. The third day of my summer vacation, I woke up..." Sales volume indicates this one hits home.

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*Cheech y Chong, Big Bambu, Ode Records, Inc., distributed by A & M Records, Inc., Beverly Hills, Calif., 1972. SP 77014.

The "make-work" jobs that characterized the Office of Economic Opportunity programs have done little to foster self-respect or contribution to the community. Yet there is real work which really needs to be done. There is need for schools, hospitals, libraries, parks, playgrounds, roads, community centers, day-care centers, after-school study centers, neighborhood health clinics. There is need for new railroad beds and tracks.

This Commission finds that one alternative to drug abuse is regular employment at work which is socially useful, and that to accomplish this may require job training, adult education, and day care for the children of the employed and of the student.

HOUSING:

One of the social needs of a family and an individual is, simply, a decent place to live. All other problems are compounded and intensified if they must be lived through in a cramped home, with inadequate heat or light or plumbing, and no corner in which to hide or to do homework or to be quiet. Light and room and air are essential to health and morale. The energy spent on, and the abrasiveness of, a constant battle against the draught of broken windows, against rats and roaches, against leaks and uncollected garbage, leaves little room for tolerance and understanding of each other, within a family, or for thinking things through and solving problems, for the individual. It costs too much to just survive.

And yet many people in the urban centers of New York State are left alone with this battle.

In New York State's large cities, 3.2% of housing units lack either plumbing, hot water, light, or other essential facilities. This is 195,000 housing units, or 195,000 families, of whom 145,000 live in Standard Metropolitan Statistical Area.*

Regarding overcrowding, the census definition is "more than one person to a room." There are, in New York's largest cities, 446,000 such units.

In 1965, a New York City study of unmarried mothers caring for their infants revealed that only 58% of the women with babies had a bathroom and a kitchen in their own apartment, throughout the period of the study, even though some moved several times.**

Since then, things have been getting worse. In 1968 (the most recent study available) the New York City Rand Corporation found that between 1960-1968, 180,000 housing units in that city had been lost by abandonment. The New York City Housing and Vacancy Survey of 1965-68 determined that during those four years, 107,000 units had been lost through abandonment. The rate is accelerating and, according to the Citizens' Housing and Planning Council, has continued to accelerate since then.

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*These statistics and those immediately following are from the 1970 U.S. Census of Housing, as reported by James Rowan, Citizens' Housing and Planning Council, Inc.

**Sauber, Mignon and Paneth, Janice, "Unmarried Mothers Who Keep Their Children: Research on Implications," Social Work Practice, 1965.

Have these units been replaced? In 1970, the number of residential housing units on which starts were made, throughout New York State, was 57,000. In 1971, the number of residential units finished in New York City was 19,000.* The net loss, per year, in New York City, is about 4000-5000 units.

Compounding the problem is the fact that most of the units lost are low-rent units. Most of the units built are moderate or high rent. Those who cannot afford the rentals in new buildings are either crowding more and more densely in cheap apartments or spilling into housing which was once adequate but became deteriorated to where the original residents fled and, rents being controlled, poorer people moved in.

One indication of the shortage of livable housing in New York City is that there are approximately 160,000 public housing applications on file with the New York City Housing Authority. It is estimated that 21%, or one fifth, of the city's elderly are living in housing unfit for human habitation.**

In addition to the overall shortage of housing units, there are the problems of poor design and of destruction of an old but viable, living neighborhood to replace it with a mammoth housing complex without services or commerce.

Oscar Newman, in Defensible Space,***, pinpoints certain design factors which affect the amount of crime which occurs in any given public housing project. These included: dead space versus traffic space (the more traffic, the safer); height of buildings (the higher towers had startlingly higher crime rates than low buildings); the number of apartments per floor (the fewer, the safer, because then everyone knew his neighbor, spotted strangers, and was more interested in what a stranger was doing there). Newman, like Jane Jacobs, also stresses the "natural surveillance" of busy streets, as a safety factor. In neighborhoods where the streets are lined with stores, and the stores are open evenings, and people use them, there is much less crime than in areas with large housing projects and no commercial space.

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* Report of New York City Planning Commission, 1972.

** Press Release, Citizens' Housing & Planning Council of New York, Inc., Jan. 21, 1974.

***Newman, Oscar, Defensible Space, Macmillan Co., New York, 1972.

In addition to the safety factor, there is the livability factor, the sense of community and of neighborliness engendered where there is mixed usage, that is, homes, shops, schools and theater, in contrast to a monolith of housing units alone.

According to the Citizens' Housing and Planning Council, the validity of Newman's findings, like the theories of Jane Jacobs, is generally acknowledged. Whether they will be utilized in future we do not know. There has been so little housing designed since publication of Newman's study that one cannot yet gauge the extent to which his findings have been acted upon.

It is clear that drug addicts and abusers need jobs and decent housing; that rehabilitated drug addicts and abusers need jobs and decent housing, so they do not have to cope with the stress of unemployment and poor housing and, in trying to cope, catapult back into the flight of drug abuse; people who are not on drugs but are "at risk" need jobs and decent housing for the same reason. Everyone needs "a room with a view," a door to close, and a friendly street to walk.

We are convinced that until we recognize and acknowledge that our families are in trouble, and that enabling them to work their way out of trouble is a top priority, we are in the position of the mother of the 14 year old girl who helped her lie rather than face the fact that the child needed her. We are not so poor, financially or ethically, but that, once we acknowledge the problem, we will have something to offer toward a solution.

CHAPTER VI

THE MEDIA

"(With regard to alcohol), except in special medical circumstances, the hazard is not in use, but in overindulgence. This is a danger inherent in virtually every human activity - eating ice cream, for example. To require advertisers to run cautionary notices against the misuse of products that are harmless when used properly (in this case, in moderation) seems to me to be against common sense."

Letter from the Publisher
of a Major Eastern Newspaper

ALCOHOL

The Commission to Evaluate the Drug Laws has taken the position, supported by most media research experts,* that basic attitudes toward substance abuse cannot be manipulated, but they can be reenforced. However, encouraging young people to use alcohol or drugs is much easier than discouraging such use, particularly because arousing an interest in the subject itself stimulates people to experiment. The arousal of interest in alcohol is a regular feature of all branches of the media. Although self-regulation on the part of television and radio precludes the airing of commercials for distilled spirits, beer and wine are freely advertised. Indeed, one of the most successful advertisements for beer encourages "more than one". The wine producers report phenomenal growth in sales since frequent television advertising was undertaken several years ago. Aimed specifically at the young, (Taylor Wines' "The Answer Grape", for example), commercials for wine have been considered a significant factor in the increase in sales of wine by 1,207,000 gallons (nationwide) from 1972 to 1973, or 12.4%. Although low alcohol-content wines enjoyed a certain popularity in 1972, by 1973 the principal increases were in the sale of table wines, from 3,504,000 gallons to 4,574,000 gallons.

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*See: Publications of the University of Connecticut Communication Research Program, Drug Abuse Information Research Project, Nos. 1, 8, and 9.

Despite current prohibitions on television commercials for distilled spirits, the licensed beverage industry has far from given up hope that they can penetrate to television. The president of one of the nation's largest distillers (Seagram)* stated:

> It doesn't look at this time as though we are going to break through into TV. However, the advantages in terms of speeding up to a tremendous degree our ability to communicate with the consumer would make it a very pursuable thing. Even if the door opens just a little bit, then we, as marketers of distilled spirits, should make every effort to use that particular medium. There is a lack of logic where wine and beer advertising is (sic) permitted on TV and radio and distilled spirits are not. Where do you draw the fine line?

As part of a campaign by the licensed beverage industry to stimulate sales among young consumers, 1973 saw an increase in television advertising for non-alcoholic cocktail mixes. This device may be designed to "open the door just a little bit" to hard liquor advertising, but even on their own, mixer and cocktail recipe ads encourage youngsters to experiment with alcohol.**

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*Quoted in the Executive Newsletter, August 31, 1973.

**Executive Newsletter, September 7, 1973.

We agree, in a sense, with the president of Seagram. We cannot see very much distinction in using a family medium, such as television, to merchandise wine and beer, if there is logic to the prohibition of advertising for distilled spirits. The vast increases in wine consumption in the United States by young people, and the experience of the French and Italians with their high incidence of wine-alcoholism leads us to conclude that broadcasters should take voluntary action to discontinue advertisements for wine and beer in the broadcast media, and, failing such voluntary action, the Federal Communications Commission should seriously evaluate the possibility of banning such messages by regulation.

In our chapter on the nature of the drug problems, we pointed out that there is nothing wrong with people's basic attitudes toward alcohol in our state and in the nation. However, the continual reenforcement of the message that alcohol signifies pleasure and success may undercut the good judgment of many of our citizens, especially the young.* This is significant to us because of the proven ineffectuality of television messages attempting to instill caution with regard to drinking and driving.**

Moreover, a number of highly responsible witnesses have testified at our public hearings that permissive advertising of alcohol bears directly upon the subject of all substance abuse, for two reasons: First, it promotes the concept that something ought to be available for a "high". Second, such advertising tends to impair the credibility of authority figures who perform regulatory, treatment and prevention functions with regard to drugs and alcohol, by sending out the double message that chemically induced joy is acceptable, providing the chemical is acceptable. Most Americans do not, in fact, believe that. Advertising may, however, persuade youngsters that most Americans hypocritically do believe in the truth of that message. This was the substance of testimony of representatives of the Suffolk County BOCES, of the Alcoholism Services of the Onandaga County Department of Mental Health, of the Long Island Council on Alcoholism and of the Rensselaer County Mental Health Board.

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*Between 1965 and 1970, the 18-through-34 "youth market" had a numerical gain, for all alcoholic beverage sales, of 6.6 million. The 18-through-24's accounted for 3.9 million of the increase, the 25-through-34's only 2.7 million.

**K.E.Cook and W.E.Ferguson, "What Do Teenagers Really Think of Traffic Safety," TRAFFIC QUARTERLY, 22:237-243, (1968)

Not only is alcohol freely advertised on television in the form of wine and beer, and suggested in the form of mixers and cocktail constituents, it is also used as a subject of humor and general approval in the content of many programs. A survey by the University of Connecticut Communication Research Program demonstrated that from Monday to Sunday (excluding, by accident, Thursday night figures which then included The Dean Martin Show), there were 44 mentions or depictions of alcohol use on humor shows and 50 on serious shows. Only twice was alcohol refused. Alcohol tended to be depicted humorously 35 times, seriously 27 times, excitingly 8 times, favorably 30 times and unfavorably 18 times. The researcher evaluated the presentations as follows:

> alcohol is "fun"; it is social, has generally positive social (and often physical) consequences; it is often joked about and is generally spoken of and shown in a positive light; it is the most prevalent prime time drug.

Had The Dean Martin Show been included, we can only guess at the even further trend of the statistics. That singular NBC entry features repeated references to alcohol as virtually the only source of laughter or of any human relationship.

Alcohol has not always been as great a source of humor as it is today. Before the great national mistake known as Prohibition, alcohol was frequently treated as a subject of respect. The reasons were clearer in those days. The industrial revolution had brought great progress to our nation, but great suffering among workers. Ghetto life for the American working class in the 19th and early 20th centuries has only recently been proclaimed romantic by nostalgic historical revisionists. In fact, workers lived with disease, mental illness, violence and poverty. Alcoholism was rife, and few who witnessed the suicides and the insanity produced by alcohol prior to Prohibition could laugh about it.

Prohibition, itself, became the joke. The law was flouted and organized crime flourished as never before. Since that time, although the social costs of alcohol abuse have continued to rise, America has remained persuaded that the joke known as Prohibition still applies to all intemperate use of alcohol. In a way which would shock and offend all decent people if used in the context of heroin, alcohol humor abounds on television, despite the fact that, as a nation, we have at least twenty times as many alcoholics as we have heroin addicts. In the ghetto, alcohol has never been a joke, and is not one now. Dr. James Curtis, one of New York City's leading pediatric psychiatrists, has told the Commission staff that for fifteen years he has been witnessing the transition of inner-city youth to alcohol abuse from opiate and depressant abuse. As in the case of heroin, only when the problem spills across the boundaries of the neighborhoods of the poor, do the rest of us begin to lose our sense of humor about the subject.

Consistent with our duties and responsibilities under the First Amendment, we cannot go further than to make this statement with regard to television program content. We sincerely hope that the network executives and artists responsible for program content will avoid humorous depictions of alcoholic intemperance in the future.

Another concept advocated frequently by witnesses at our hearings who expressed concern about the advertising of alcoholic beverages was that a cautionary statement be included on all package labels and in all printed promotional literature, including advertisements and displays. According to these witnesses, the statement could be extremely simple: for example, "AVOID OVERINDULGENCE", "DRINK SENSIBLY" or "DON'T DRINK IF YOU'RE GOING TO DRIVE". The theory behind this proposal is not that it will discourage irresponsible drinking, although it might. The theory is that a contributory factor to drug use is a permissive attitude toward alcohol use. For more than three years, this Commission has received representations from young people who are seriously concerned about the hypocrisy of promoting alcohol use, on the one hand, and penalizing alternative drug use, on the other. The argument is not that children have a right to use drugs out of spite because their parents use alcohol. Rather, the argument is that children cannot fully believe that chemical substances may be harmful, when alcohol, the most abused chemical we know, is treated so positively in the majority of printed or visual representations which refer to its use.

The printed media and the licensed beverage industry appear to be in substantial agreement, as evidenced by the quotation at the start of this chapter, that because the Surgeon General has not determined that alcohol use may be injurious to one's health, no cautionary notice need be placed upon advertising accepted in the printed media. While it is, of course, true that overindulgence rather than sensible use of alcohol is the problem, as contrasted with any cigarette use, which is categorically harmful, the basic issue cannot be evaded: overindulgence in alcohol _is_ a national problem, and those who equate such overindulgence with overeating ice-cream may be expressing a specious argument to disguise a quite substantial vested interest.

Advertising revenue in the printed media from alcoholic substances is extraordinarily high. One distiller listed an advertising budget of over $15 million for 1973, an increase of $5 million over 1972. The amounts spent nationally by liquor advertisers in newspapers in 1972 and the amounts spent in 1973 for space in magazines has been itemized and includes such sums as nearly $17 million in income to _Time_ Magazine to over $1 million in _Psychology Today_. (See Figures 1 and 2.)

Figure 1.

Following is the amount spent by liquor advertisers in 1972 in newspapers on their brands as tabulated by Advertising Age:-

Afrikoko Liqueur	$ 15,097
Almaden Brandy	15,575
American Dist.(Multi-Products)	6,064
Ambassador Scotch	275,526
Ancient Age	274,009
Ancient Age (Multi-Products)	176
Ancient Ancient Age	88,898
Antique	130,877
Aristocrat Brandy	10,370
Aristocrat Gin	2,091
Aristocrat Vodka	905
Arrow Brandy	39,546
Arrow Cordials	8,925
Arrow Vodka	38,699
Asbach Brandy	53,904
Bacardi Corp. (Institutional)	529
Bacardi Rum	488,004
Ballantine's Scotch	299,117
Barclay's	51,794
Barton's QT	935,985
Beam	5,109
Beam's Choice	77,887
Beefeater Gin	240,543
Bellow's (Multi-Products)	90,833
Bell's Scotch	35,414
Bisquit Cognac	10,064
Black & White Scotch	367,870
Black Velvet	310,082
Blackberry Driver	159
Blackberry & Cherry Julep	1,206
Blackberry Julep	4,143
Bols Brandy	18,740
Bols Creme De Cacao	9,612
Bols Creme De Menthe	6,293
Bols La Creme De La Creme	6,393
Bols Peppermint Schnapps	2,026
Bols Sloe Gin	7,062
Bols Liqueurs	46,054
Bombay Gin	64,752
Bond & Lillard	17,441
Boord's Gin	6,234
Booths High & Dry Gin	190,514
Borzoi Vodka	33,078
Bourbon De Luxe	23,247
Burke & Barry	246,065
Cabin Still	54,885
Calvert Extra	1,027,193
Calvert Gin	77,200
Calvert Multi-Prods	$ 74,754
Campari Liqueur	73,222
Canada Dry	54,206
Canada Dry Bourbon	4,937
Canada Dry Gin	8,392
Canada Dry Vodka	818
Canada Dry (Multi-Products)	49,755
Canada House	33,256
Canadian Club	1,074,688
Canadian Deluxe	18,377
Canadian Lord Calvert	376,848
Canadian Ltd.	14,294
Canadian Mist	750,153
Canadian OFC	161,673
Canadian Reserve	12,001
Canadian Rich & Rare	226,756
Carib Cup Liqueur	50,899
Carrington	42,976
Carstairs White Seal	219,151
Cascade	55,952
Chapin & Gore	58,168
Cheri Suisse Liqueur	65,780
Cherry Heering Liqueur	12,933
Chivas Regal Scotch	334,630
Chivas Regal (Multi-Products)	421
Christian Bros. Brandy	67,156
Clan MacGregor Scotch	181,886
Club Cocktails	17,443
Cluny Scotch	43,137
Corby's Reserve	214,990
Coronet Brandy	160,065
Crawford Scotch	36,173
Cream of Kentucky	43,128
Crow Light	668,909
Crown Russe Vodka	85,535
Cutty Sark Scotch	804,789
Dark Eyes Fruit Flavored Vodka	3,522
Dark Eyes Vodka	14,876
David Nicholson 1843	16,203
Dewar's Ancestor Scotch	17,169
Dewar's White Label Scotch	829,268
Dickel Tennessee	23,080
Distillers Bond	831
Distillers Light	1,836
Distillers Pride	17,855
Dolfi French Cordials	17,659
Don Q Rum	44,858
Drambuie Liqueur	155,009

Figure 1. (continued)

Du Bouchett Brandy	$ 17,732
Du Bouchett Creme De Menthe	66,986
Du Bouchett Fruit Brandies	107
Du Bouchett Peppermint Schnapps	11,308
Duet Cocktails	32,910
Early Times	508,175
Echo Spring	75,603
Eldorado Rum	11,242
Embassy Club	41,313
Evan Williams	64,994
Ezra Brooks	163,841
Finlandia Vodka	16,354
Fleischmann's Gin	44,402
Fleischmann's (Multi-Products)	5,119
Fleischmann's Preferred	156,128
Fleischmann's Royal Vodka	17,860
Four Roses	630,461
Four Roses Distillers (Multi-Prod)	4,907
Free Spirit	47,950
Frost 8/80	624,076
G & W (Multi-Products)	148,010
G & W Private Stock	7,762
G & W Seven Star	33,121
Galaxy	64,127
Galliano Liqueur	136,455
Gaston De La Grange Cognac	37,135
George Dickel	106,605
Gilbey's Gin	29,760
Gilbey's Spey Royal Scotch	10,993
Gilbey's Vodka	18,241
Gordon's Gin	327,603
Gordon's (Multi-Products)	1,413
Gordon's Vodka	172,603
Governor's Club	29,936
Governor's Club (Multi-Products)	863
Grand Macnish Scotch	287,838
Grand Marnier Liqueur	49,468
Grande Canadian	340,653
Grant's Scotch	38,834
Haig Scotch	203,468
Haig & Haig Pinch Scotch	308,407
Haller's (Multi-Products)	33,576
Haller's Vodka	223
Harwood Canadian	317,163
Heaven Hill	40,280
Henry McKenna	110,718
Heublein Cocktails	932,646
Hill & Hill	27,396
Hiram Walker's Brandy	9,697
Hiram Walker's Cordials	252
HiramWalker's Gin	112,146
Hiram Walker's Little Brown Jug	$ 6,768
Hiram Walker's (Multi-Prod)	53,998
Hiram Walker's No.Light	36,891
Hiram Walker's Priv.Cellar	26,387
Hiram Walker's Spec.Can.	328,741
Hiram Walker's Vodka	538
House of Stuart Scotch	39,700
Hudson Bay Scotch	36,930
I. W. Harper	151,695
Igor The Invisible Liqueur	317,011
Igor Vodka	3,835
Imperial	696,874
Inver House Scotch	368,918
J&B Scotch	453,843
J. Bavet Brandy	18,362
J. W. Dant	108,808
J. W. Dant Charcoal Perf.	121,308
J. W. Dant (Multi-Prod)	61,346
J. W. Dant Olde Bourbon	36,754
Jack Daniels	257,160
Jacquin's Brandy	3,021
Jacquin's Cordials	446
Jacquin's Creme De Menthe	116
Jacquin's London Tower Gin	331
Jacquin's (Multi-Products)	7,855
Jacquin's Peppermint Schnapps	625
Jacquin's Rum	963
Jacquin's Vodka	1,023
Jameson Irish Whisky	13,695
Jim Beam	635.141
John Begg Scotch	127,082
Johnnie Walker Scotch	1,042,761
Jose Cuervo Tequila	43,648
Kasser's (Multi-Products)	84,222
Kamchatka Vodka	23,784
Kentucky Beau	143,974
Kentucky Tavern	215,763
Kessler	396,556
King George IV Scotch	13,535
King William IV Scotch	269,521
Laird's Apple Jack Brandy	1,317
Laird's Canadian	35,180
Lang's Scotch	67,478
Lauder's Scotch	264,875
Leilani Hawaiian Rum	19,234
Leroux Anisetts	11,158
Leroux Brandy	65,562
Leroux Coffee Brandy	8,998
Leroux Creme De Cacao	10,502
Leroux Creme De Menthe	28,609

Figure 1. (continued)

Leroux Liqueur	$ 2,656
Leroux Peppermint Schnapps	8,259
Leroux Sloe Gin	13,529
Leroux Triple Sec	4,150
Lochran Ora Liqueur	73,163
Lord Barry Scotch	11,465
MacNaughton	685,793
McColl's Scotch	58,689
McGills	40,488
McMaster's	103,396
McMaster's Scotch	56,840
Majorska Vodka	71,911
Maker's Mark	39,342
Mattingly & Moore	180,855
Metaxa Liqueur	133,619
Mr. Boston Brandy	8,135
Mr. Boston Cocktails	36,316
Mr. Boston Egg Nog	748
Mr. Boston Five Star	4,122
Mr. Boston Light	11,475
Mr. Boston (Multi-Products)	21,141
Mr. Boston Vodka	6,768
Muirhead's Scotch	95,570
National Distillers (Multi-Products)	31,348
Old Charter	180,627
Old Crow	250,080
Old Fitzgerald	163,310
Old Fitzgerald 1849	2,791
Old Fitzgerald Prime	164,908
Old Forester	410,432
Old Grand-Dad	376,249
Old Hickory	13,724
Old Master	10,589
Old Smuggler Scotch	145,540
Old Taylor	100,910
Old W. L. Weller	78,393
100 Pipers Scotch	800,860
Orange Driver	10,351
Ostrova Vodka	40,204
Park Avenue Imports (Multi-Products)	12,818
Park Avenue Liqueurs	6,135
Park & Tilford	3,950
Park & Tilford Spec.Selection Scotch	58,077
Party Tyme Cocktails	27,012
Passport Scotch	331,383
Paul Jones	50,079
Philadelphia	50,032
Plymouth Gin	48,794
Popov Vodka	154,221
Puerto Rican Rums	158,720
Rebel Yell	41,119

Relska Vodka	$ 160,499
Remy Martin Cognac	249,307
Renfield Dry Canadian	118,275
Renfield Imp.(Multi-Prod)	1,530
Ron Llave P.R. Rum	11,288
Ron Superior Rum	44
Ronrico Rum	208,638
Royal American	19,632
Royal Canadian	352,585
Royal Gate Vodka	13,783
Sabra Liqueur	61,390
St. Dennis Scotch	23,031
Sambuca Romana Liqueur	17,382
Sazerac	16,924
Sazerac (Multi-Products)	11,202
Schenley Brandy	710
Schenley Champion	37,925
Schenley Dist.(Multi-Prod)	2,232
Schenley (Multi-Products)	101,347
Schenley Reserve	306,282
Schenley XL	15,179
Schenley XL Light	13,440
Scotch Comfort	75,393
Seagram's Benchmark	282,183
Seagram's Crown Royal	53,330
Seagram's Distillers	2,168
Seagram's Dist.(Instutional)	24,656
Seagram's Seven Crown	1,693,375
Seagram's VO	1,113,230
Seagram's Gin	190,606
Seagram's (Multi-Products)	48,342
Sendai	21,811
Sir Malcolm Scotch	21,578
Smirnoff Gin	136
Smirnoff Vodka	514,554
Something Special Scotch	10,614
Southern Comfort	454,615
Squires Gin	12,599
Stock Brandy	114,795
Stock Cordials	34,762
Stolichmaya Vodka	28,968
Sunny Brook	43,533
Suntory Royal	17,182
Taaka Vodka	145,505
Tanqueray Gin	211,078
Teacher's Scotch	127,528
Ten High	406,262
Thorne's Scotch	38,853
Tia Maria Coffee Liqueur	23,634
Usher's Scotch	124,657
Vandermint Liqueur	89,917

Figure 1. (continued)

Vat 69 Scotch	$ 57,337
Verana Liqueur	51,630
Very Old Barton	63,915
Virgin Bourbon	11,633
Virgin Islands Rum	323.661
Waterfill & Frazier	8,670
Waterfill & Frazier(Multi-Products)	4,903
Walker's De Luxe	433,785
White Horse Scotch	74,821
White Wolf Vodka	20,319
Wild Turkey	303,714
William Lawson Scotch	16,056
William Penn	33,943
Wilson	14,105
Windsor Supreme	797,764
Wolfschmidt Vodka	177,967
Yellowstone	49,914
Zhivago Vodka	84,442
WINES:-Adriatica	13,547
Alexis Lichine	101,362
Alianca	11,100
Andre	295,150
Andre Champagne	88,565
Andre Cold Duck	134,475
Brotherhood Winery	47,564
Campari	61,634
Carillon	26,857
Chauvenet	28,968
Cockburns	22,398
Gallo	175,601
Gallo Champagne	111,401
Gallo Cold Duck	30,271
Hudson Valley Winery	20,159
Inglenook	16,207
Isabel Rose	22,789
Julius Kayser Wines	21,221
Lagosta	23,579
Lagosta Rose	5,519
Lancers Vin Rose	13,131
M. Lamont	37,268
Manischewitz	18,023
Mistala	23,488
Noilly Prat Vermouth	11,226
Paul Masson	168,599
Raphael	31,746
Romano	31,157
Stock Vermouth	73,514
BEERS:-Altes	12,053
Anheuser Busch Beers	63,311
Asahi	11,681
Ballantine	101,678
Ballantine Beer & Ale	508
Biber-Brau	10,848

Black Label	$ 7,825
Blatz	30,390
Brew 102	15,975
Budweiser	163,749
Burger	10,998
Busch Bavarian	60,946
Carling Black Label	44,390
Carling Brewing Co.	2,490
Carl. Bl.Label & Red Cap Ale	267
Carlsberg	44,790
Carta Blanca	22,309
Coors	22,890
Coors Co.(Institutional)	16,512
Coors Dist'g.(Institutional)	207
Falstaff	83,934
Guinness	15,285
Heidelberg-Alt	11,119
Heidelberg Beer	1,859
Hop N Gator	11,840
Hudepohl	26,482
Iron City	13,333
Jax	11,098
Jos.Schlitz Brewing Co.	7,584
Lowenbrau	53,158
Lucky Breweries(Institutional)	34
Lucky Lager	20,715
Malt Duck	38,697
Maximus Super	16,236
Miller Ale	6,134
Miller Brewing Co.	7,444
Miller Brewing (Institutional)	2,816
Miller High Life	43,257
Miller Malt Liquor	5,456
Molson	83,788
Molson Ale	50,481
Molson Ale & Beer	288
National	58,542
Old Milwaukee	17,495
Olympia	84,092
Olympia Brewing (Institional)	2,873
Pabst Blue Ribbon	74,932
Piels	29,082
Primo	29,392
Regal Select	23,792
Rheingold	111,951
Ruppert Knickerbocker	32,486
Schaefer	323,133
Schlitz	98,375
Schmidts of Philadelphia	24,398
Stag	45,090
Stroh Brewery (Institutional)	3,336
Strohs	73,712
Tuborg	78,573

Figure 2.

Following is the amount spent by liquor advertisers in 15 major magazines in 1973 and number of pages. (Source: PIB)

BEER, WINE & LIQUOR DOLLARS

MAGAZINE	1973	1972	Difference Gain or Loss	% Dif.
Time	16,946,268	15,064,423	1,881,845	12.5
Newsweek	12,337,103	12,169,444	167,659	1.4
Playboy	8,911,830	9,454,819	- 542,989	- 5.7
Sports Illustrated	8,130,790	8,184,035	- 53,245	- .7
TV Guide	4,513,366	4,304,251	209,115	4.9
Esquire	4,307,545	4,060,821	246,724	6.1
US News & World Report	4,242,968	4,389,076	- 146,108	- 3.3
New Yorker	3,798,009	3,310,184	487,825	14.7
New York Magazine	2,234,114	1,494,435	739,679	49.5
Gourmet	1,884,173	1,544,813	339,360	22.0
Ebony	1,846,910	1,893,198	- 46,288	- 2.4
Cosmopolitan	1,545,093	1,331,009	214,084	16.1
Penthouse	1,371,413	429,783	941,630	219.1
Psychology Today	1,073,125	602,005	471,120	78.3
Southern Living	833,314	796,178	37,136	4.7
Total 15 Magazines	73,976,021	69,028,474	4,947,547	7.2
General Magazines	86,886,353	80,953,330	5,933,023	7.3
Newspaper Supplements	1,981,341	1,530,668	450,673	29.4
Total PIB Publications	88,867,694	82,483,998	6,383,696	7.7

PAGES

MAGAZINE	1973	1972	Difference Gain or Loss	% Dif.
New Yorker	479.22	440.72	38.50	8.7
Newsweek	427.65	463.88	- 36.23	- 7.8
Time	407.20	375.19	32.01	8.5
New York Magazine	397.27	295.45	101.82	34.5
Sports Illustrated	319.41	343.03	- 23.62	- 6.9
Esquire	290.90	269.59	21.31	7.9
Gourmet	224.90	190.07	34.83	18.3
US News & World Report	209.02	219.00	- 9.98	- 4.6
Playboy	191.28	212.53	- 21.25	- 10.0
Cue	185.24	189.77	- 4.53	- 2.4
Ebony	136.91	152.81	- 15.90	- 10.4
Cosmopolitan	134.18	127.06	7.12	5.6
Harpers Magazine	117.61	121.74	- 4.13	- 3.4
Atlantic	109.28	129.73	- 20.45	- 15.3
Southern Living	103.10	118.59	- 15.49	- 13.1
Total 15 Magazines	3,733.17	3,649.16	84.01	2.3
General Magazines	5,100.09	4,805.34	294.75	6.1
Newspaper Supplements	244.93	191.64	53.29	27.8
Total PIB Publications	5,345.02	4,996.98	348.04	7.0

Figure 2. (continued)

LIQUOR

DOLLARS

MAGAZINE	1973	1972	Difference Gain or Loss	% Dif.
Time	15,452,050	13,375,709	2,076,341	15.5
Newsweek	11,044,734	10,843,408	201,326	1.9
Playboy	8,010,830	8,061,436	- 50,606	- .6
Sports Illustrated	7,574,363	7,336,049	238,314	3.2
TV Guide	4,439,540	3,532,962	906,578	25.7
US News & World Report	3,929,728	4,099,935	- 170,207	- 4.2
Esquire	3,888,293	3,636,855	251,438	6.9
New Yorker	3,104,931	2,677,670	427,261	16.0
New York Magazine	1,842,457	1,219,920	622,537	51.0
Ebony	1,566,581	1,625,517	- 58,936	- 3.6
Cosmopolitan	1,319,593	1,051,309	268,284	25.5
Gourmet	1,267,560	1,080,660	186,900	17.3
Penthouse	1,223,888	333,315	890,573	267.2
Psychology Today	868,350	439,375	428,975	97.6
Southern Living	771,024	735,470	35,554	4.8
Total 15 Magazines	66,303,922	60,049,590	6,254,332	10.4
General Magazines	77,067,379	68,958,725	8,108,654	11.8
Newspaper Supplements	1,521,587	1,251,644	269,943	21.6
Total PIB Publications	78,588,966	70,210,369	8,378,597	11.9

PAGES

MAGAZINE	1973	1972	Difference Gain or Loss	% Dif.
Newsweek	382.66	415.68	- 33.02	- 7.9
New Yorker	377.58	340.05	37.53	11.0
Time	372.98	336.84	36.14	10.7
New York Magazine	322.35	232.26	90.09	38.8
Sports Illustrated	298.97	309.23	- 10.26	- 3.3
Esquire	261.55	240.93	20.62	8.6
US News & World Report	193.20	205.21	- 12.01	- 5.9
Playboy	173.14	183.75	- 10.61	- 5.8
Cue	149.00	169.47	- 20.47	- 12.1
Gourmet	145.71	126.31	19.40	15.4
Ebony	115.26	131.06	- 15.80	- 12.1
Cosmopolitan	114.51	101.07	13.44	13.3
Southern Living	95.44	110.32	- 14.88	- 13.5
TV Guide	82.63	73.32	9.31	12.7
Psychology Today	81.66	49.34	32.32	65.5
Total 15 Magazines	3,166.64	3,024.84	141.80	4.7
General Magazines	4,317.36	3,899.16	418.20	10.7
Newspaper Supplements	182.15	153.49	28.66	18.7
Total PIB Publications	4,499.51	4,052.65	446.86	11.0

In the face of these statistics, we believe that rare instances of industry advertising which highlight the need for responsible drinking do not suffice. Occasional black and white pages in a magazine warning against overindulgence which are sandwiched between glorious full-color promotional materials for name brands are inferred to have no impact whatever. We firmly recommend that the publishers of newspapers and magazines reevaluate their positions with regard to requiring cautionary notices on liquor advertisements. We also recommend that the United States Treasury Department, the Federal Trade Commission and the Surgeon General's Office evaluate the possibility of a requirement that bottle labels carry similary cautionary notices.

We believe that even if such cautionary notices did not actually reduce overindulgence, they would heighten the credibility of those charged with the responsibility for discouraging all forms of substance abuse.

DRUGS

Our first apprehension that public service media advertisements against illicit drug use were not only ineffective, but were positively dangerous, arose when we were studying the possibility of using media campaigns to stimulate employment opportunities for rehabilitated addicts. At that time, we received a considerable amount of information that anti-drug advertisements were ineffective. For example, from Dr. Daniel X. Freedman, we heard: "Almost all of the drugs in illegal currency today require a belief or faith on the part of the user that they are going to make him feel better. Once having made that commitment, it is highly unlikely that a user will quit on the basis of advertising. What advertising can do is to provide reasonable options for not taking drugs in the first place."

Because most advertisers have abandoned the concept of the "soft sell", experts at merchandising consumer items recommended that agencies such as the New York State Drug Abuse Control Commission and the New York City Mayor's Council on Drugs, sponsor hard-hitting, sloganeering messages on television, on billboards, in magazines and newspapers, and in specially prepared pamphlets.

When we spoke with employers about hiring reformed addicts, we found that a number of them had been persuaded, at least in part, by such advertisements as "Don't Join the Living Dead" and "Why Do You Think They Call It Dope?" that addicts were fools who could never effectively be rehabilitated. We pursued this line of inquiry and found widespread agreement among treatment experts that such advertisements were counter-productive and that by lowering the self-esteem of drug users even further, they were deterrents to abstinence and rehabilitation, rather than to drug use.

Some of the anti-drug commercials defied credibility and others aroused great anger. Youngsters universally reacted with disbelief when told by athletes whom they suspected of using drugs that drug use was bad. Residents of poorer neighborhoods reacted with a sense of outrage when commercials appeared warning rich youngsters of the penalties for drug use in other countries. We found that both types of announcements weakened the status of those in authority truly concerned about substance abuse.

Testimony throughout the state at our public hearings regarding prevention has confirmed these findings. However, the last sentence quoted from Dr. Freedman seemed to us to contain the germ of an idea: "What advertising can do is to provide reasonable options for not taking drugs in the first place."

One out of every six commercials* on television deals with some form of drug or chemical. At least ten percent of the advertising revenue of broadcasters derives from the promotion of such products. Although there is no proof that such advertising actually encourages the misuse of drugs, there is a great deal of evidence that unnecessary use of drugs and chemicals (with resultant profits to their manufacturers) is the goal of such advertising. Recently, Bristol-Myers sponsored a program narrated by Joanne Woodward and entitled "The Fragile Mind -- Five Cases of Emotional Stress". Everyone would agree that the subject matter was extremely sensitive. During the course of the program, which lasted but one hour, there were two commercials for Excedrin, two commercials for Excedrin P.M., one commercial for Congespirin, three commercials for anti-perspirants, one commercial for a hair-spray, one commercial for a nasal spray, one commercial for Bufferin and one commercial for a cough syrup (Silence is Golden). All in one hour. If television drug commercials have no market-expansion effect, why are there so many of them?

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*In prime time.

It is true that broadcast drug advertising is tightly regulated, both by the Federal Trade Commission and by the broadcast industry. The Federal Trade Commission sees to it that drug commercials are true, in terms of claims made for specific products. For example, the FTC has taken action against producers of headache remedies who advertise their product, either directly or indirectly, for relief of tension. This form of advertisement leads the viewer to believe that a combination of aspirin and caffeine can ease daily anxieties, and, what is more, that daily anxieties should be eased chemically rather than through problem-solving. When the FTC brought their action, the sponsor, a subsidiary of one of the largest corporations in the world, quickly changed the commercials to moot the issue. Now they advertise their headache remedy as one which will "hit and hold the highest level" of pain relief. A number of authorities have questioned whether these new commercials use language to hint that the product can produce a "high."

Although the FTC does a brilliant job in assuring that most commercials will be truthful, it cannot possibly keep up with the shifting techniques of advertisers, who can change commercials quickly and often. After having been criticized for advertising a stomach and headache remedy by inventing an illness called "The Blahs", to expand the market for the drug, a manufacturer produced a series of entertaining comic spot announcements. Soon thereafter, however, it aired a commercial which carried the message that the product would bring relief from the discomfort of noise and anxiety. Criticized again, the manufacturer now airs a sober series of commercials cautioning viewers that the product is strong medicine and should not be used "for every little ache and pain." But what ingenious commercial will they air tomorrow?

Moreover, the FTC does not have the power to regulate the frequency of drug commercials. As one witness commented at our hearing in Poughkeepsie, "We may have reached the point where we have more commercials for headache remedies than there are headaches." Except for persons employed by the media, all of the witnesses at our hearings recommended action to somehow curtail or counteract this deluge of drug commercials. Witnesses pointed out that many over-the-counter chemical products are really quite dangerous, especially to children. Restrictive warnings required on labels, such as "Keep product away from eyes", or "Keep out of the reach of children" are never aired. Recently, as an incident of broadcast industry self-regulation, notices have begun to appear on drug product commercials that they should be used according to label instructions.

Arguably, this does not go far enough. In nearly all of the contexts in which headaches are depicted on television, drug remedies are sold. In nearly all of the contexts in which digestive problems or irregularity are seen on television, non-prescription drugs are sold. In nearly all of the contexts in which sleeplessness is represented on television, or lack of alertness, drug remedies are sold. In nearly all of the contexts in which colds, hay fever, sore throats, muscle aches, stiffness or virtually any discomfort, short of a debilitating illness, are depicted on television, drug products are sold. No group of commercials fosters the concept that social acceptance depends on chemical use more than the deodorant, mouth wash and anti-bacterial soap advertisements. And these messages appear in the context of continuing advertisements for cigars, beer and wine.

While the need exists for self-medication, the dangers of reliance upon drugs, rather than upon prevention and alternative forms of relief, have never been clearly spelled out on television. Physicians believe that exercise and roughage are far more acceptable remedies for temporary irregularity than laxatives. Hot milk and the completion of routine household tasks remain preferable remedies for sleeplessness than drugs. And the depiction of persons warmly dressed, rather than, as in some cold remedy commercials, inadequately clothed for winter, would be preferable as a concept of cold prevention to the depiction of the illness and the drug alone.

The Federal Communications Commission, which regulates all broadcasting, has established a policy known as "the fairness doctrine". The fairness doctrine requires that over a period of time, matters in controversy shall be dealt with on television in such a way that all reasonable positions and points of view are represented. We find that the volume of drug advertising on television, and its content, which always depicts discomfort in terms of chemical remedies, violates the fairness doctrine by presenting only one view of self-medication, good health and preventive medicine: the view of the pharmaceutical manufacturer.

We recommend that the Federal Communications Commission require, as it once did before when cigarettes were still being advertised on television, that the broadcast media make free time available (in prime time) for spot announcement counter-commercials to respond to the underlying assumptions of the drug commercials. Such counter-commercials would not refer to drugs at all. They would reply directly to the sales techniques of the drug commercials by demonstrating methods of preventing discomfort and minor illnesses, as well as methods of gaining relief from such problems as sleeplessness and irregularity. We believe fairness dictates that if pharmaceutical manufacturers should be free to offer home remedies for truthful sale, then others without a profit motive should be equally free to inform the public why such products may not be necessary.

AFTERWORD: ON VALUES AND FUNDING PRIORITIES

Many of those who replied to the Commission's questionnaires and letters of inquiry regarding prevention of drug abuse, and who testified at the hearings on this subject, addressed themselves to the broad alternatives to drug abuse which are required, and to the change in our value system which is necessary to obtain these alternatives. Since a nation's dominant value system is graphically expressed in the funding priorities of its government, talk of values is not so abstract as it may sound.

When this Commission speaks of values, we speak of what the policy makers consider important and what they are willing to pay for. We speak of young Americans' awareness of official confusion in this area, and their consequent loss of respect for authority figures. We speak of the hopelessness of the poor and of the malaise of purposelessness which affects the middle class.

Some of the answers the Commission received follow:

ON SOCIAL PROBLEMS:

From a Drug Rehabilitation Center:

"Conceptually, the most significant approach to prevention would be the meaningful beginnings of social change, that is, creating the stimulus within depressed communities (where drug-abuse is highest) towards education, decent housing and employment. Traditionally the use of welfare monies has been the approach to remedy the ghetto problems. It simply has reinforced the hopelessness associated with that life-style. In my opinion change could be effected if the recipients of public assistance received grants for efforts made, in education and the completion of same, in housing and the "cooperative" maintenance of same, all of which would certainly be tapping the resourcefulness and potential of people, and ultimately the reality of one's ability to compete, complete and live as productive members of the larger society. Drugs are not a cop-out when there is no hope, no self-esteem, no beliefs."*

From a Child Care Agency:

"From the point of view of causation, we believe that many factors contribute to drug abuse. Among them are socio-economic pressures stemming from conditions of poverty. Here the consequent sense of hopelessness and helplessness about oneself and society may influence many young people to seek escape from reality through drug induced satisfaction and fantasies. There are many other motivations. Among them are, a pressing curiosity to experiment, a need to be 'in' and 'cool,' as part of a particular peer culture, it may be an expression of rebelliousness or defiance as part of adolescent development, a protest against existing adult values, a manifestation of underlying conflict with parents or an expression of serious emotional disturbance."**

From a Private Practitioner, on the Necessity of Employment:

"I have very rarely seen a drug abuser who had a salable skill and was able to hold down a job. I think that we prohibit the entry into job training until a point at which many youngsters become disenchanted with school. In this regard, the unions are in part to blame as are the schools. I see no reason why a youngster could not enter into junior apprenticeship at the age of sixteen rather than waiting until high school graduation at the age of eighteen and why he could not be given credit for his first years of training in the union apprenticeship. I know a training program for practical nurses in New York City, under the New York City Board of Education, has been successful, in which girls in their junior year of high school are started in practical nurse training so that by the time they graduate from high school, they not only have an L.P.N. but also

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* Sherman, Bernard, Executive Director, Ardis Commune, Inc., Letter of Aug. 23, 1973.

**Rabinow, Irving, Associate Executive Director, Jewish Child Care Association, Letter of Aug. 22, 1973.

their high school diploma. I think we keep too many non-school oriented children in school too long and offer them no satisfactory alternatives to the school learning situation. I believe the job learning situation is a satisfactory one and that school credit might be given for this. Certainly the growth of alternative schools should make clear the fact that the standard school situation is lacking for some students. I believe that every youngster can and should be able to succeed at something and to persist in holding him in a situation where he is failing can only result in his turning to other forms of satisfaction which may include alcohol, drug abuse or other forms of sociopathy....

"...my earlier comments are referred to work programs in which schools, business and industry cooperate to find job placements for the students and school credit for the students and perhaps further learning experience for the students either on the job or in school."*

From a Community Mental Health Clinic:

"Some of the factors which are important in the development of drug and alcohol abuse are the lack of recreational and social facilities in our country for both youth and adults; lack of acceptable social outlets and the low socio-economic conditions in our area."**

ON PERSONAL PROBLEMS AND VALUES:

On Responsibility:

"Perhaps the best place to begin is to examine closely an important misconception widely held by much of society and one which we believe to be a crucial point for discussion, i.e., the belief that drug abuse is the problem in and of itself. We believe the fallacy lies in not understanding that it is merely symptomatic of other existing problems.

"How this misconception has come about is not surprising when one examines the society at large. We feel strongly that we are living in a society that is extensive in its drug orientation and that this is evidenced by the emphasis placed upon using drugs in some form for 'any occasion.' A quick look at the media, for example, immediately identifies its role in perpetrating this misconception and gives a clearer picture as to how society has whole-heartedly embraced it. We are constantly being advised and sometimes commanded to use drugs whenever we don't feel 'right.' If you can't sleep - take a barbiturate; if you can't wake up - take an amphetamine; if you have a headache - take an aspirin, etc., etc. And always without question. Rarely are we directed to search for why we can't sleep or why we have a headache. The emphasis is placed upon not taking responsibility for ourselves in dealing with our own problems, but instead in placing that responsibility somewhere else - too often on drugs."*

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* Morgenstern, Leo L., M.D. Letter of Dec. 5, 1973.

**Bassiri, Reza G., M.D., Director, Fulton County Community Mental Health Clinic.

On Goals and Motivations

From Dr. Henry Brill:

"I think that the most serious lack in our present structure is a lack of provision for development of positive social and personal goals. At one time this was a function of religion. Subsequently it was in part taken over by patriotism. The tremendous Chinese successful control of opium addiction can, I think, be attributed primarily to the acceptance of strong social and individual goals by the total population. We do not seem to have a broadly effective system for creating such goals today."**

From a Drug Rehabilitation Agency:

"The emphasis should be on motivation! Human problems must be solved in human ways. Drug abuse is a distinctively human problem. The solution must come from involvement of the individual with interested role models who can satisfy their own needs within society without resorting to drugs and who can help others to find alternative ways to meet their needs without drugs. Peer group involvement is essential and must supplement didactic instruction."***

From a Medical Center:

"We have tried all the ineffective approaches to drug abuse prevention and only by very broadly defining 'improvement' can we claim a reasonable percentage of favorable results.

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* Davidson, Richard B., and Lenney, Sandy, Outreach Workers, The Cheektowaga Drug Education and Counseling Center of the Young Men's Christian Association of Buffalo and Erie County, Letter of Oct. 15, 1973.

** Brill, Henry, M.D., Director, Pilgrim State Hospital, Letter of Aug. 13, 1973.

***Curry, Andrew P., Administrator, Daytop Village, Inc., Letter of June 11, 1973.

If we ask how many non-users has each ex-addict brought about - as compared to how many users created while traveling in the other direction - we see that cure is not as infectious as addiction. I am sure if we research why, we will get involved in social motivation - and we should."*

On One's Sense of Worth

From New York City:

"When we speak of prevention in the area of drug abuse, it seems we mean to arm youngsters with the knowledge to make meaningful choices; problem solving and social skills necessary for life in our complex society and a sense of worth about himself, his fellows and their institutions."**

From Oneida:

"If the State wants to be truly effective in this whole area of prevention, cure, and rehabilitation - I heartily recommend findings ways to develop 'grass roots' groups where persons can be taken seriously as persons and their needs dealt with on a personal level."***

On Self Worth and Social Needs:

"First of all, I believe that drugs are used to compensate for feelings of ineffectiveness. Thus, inability to achieve in the school, at the job, or in our success-oriented society generally would seem to me to be the strongest contributing factor to the use of drugs....

"If the 'help' that we provide could be more responsive to the individual's needs as the individual perceives

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* Kurian, Milton, M.D., F.A.P.A., Medical Director, Department of Psychiatry, New York University Medical Center, School of Medicine, Letter of September 6, 1973.

** Lembo, Philip G., Assistant Director, District 20 Narcotics Program, N.Y.C. Board of Education, Letter of Aug. 21, 1973.

***McCleary, Stewart, Member, Narcotics Guidance Council, Oneida County.

> those needs, I believe we could intervene much more effectively. That is, when the person cites a lack of job skills, inadequate housing, etc., we should not think that counselling alone will provide assistance."*
>
> ONE SUGGESTION:
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> "Drugs, alcohol, delinquency and crime - all facets of the same problem: the inability to meet one's needs within the tolerance of society while allowing others to meet their needs. Since one individual may and often does evidence all these symptoms, we may be myopic in attempting to treat each as a discrete entity and we do so through the limitations of our drug programs, penal systems, alcohol programs, etc. Why not create private programs with the authority to command the resources of all governmental agencies, political and administrative, to assure coordination."**

AND A NOTE OF OPTIMISM:

"I think for too long problems such as drug abuse have been dealt with as if they have no ideological tie to the basic fabric of our society...

"It seems to me that we know an awful lot more about what needs to be done to deal with the problems of our modern society. We know that our educational system is failing. We know that our public welfare system metes out miserly grants that are totally inadequate for human existence. We know that our criminal justice system is at best punitive and abusive. We know that social agencies have functioned with an uneven level of success and have given

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*Blum, Barbara B., Assistant Administrator, Special Services for Children, N.Y.C. Human Resources Administration, Letter of Sept. 4, 1973.

**Curry, Andrew, op. cit. Letter of July 9, 1973.

little of their effort towards direct services in urban ghetto communities, and we know that government and, yes, our society in general has not demonstrated a commitment to a decent life and a fair chance of survival for all of its constituents. Once there is commitment, it isn't too difficult to decide what needs to be done. Once one gets past the political and self-interest reasons for tangentially relating to problems such as drug abuse, we know what should be done.

"It is when state governments and federal government give leadership and face squarely the need to infuse our many communities with the life blood of services and opportunities that we can begin to talk about solving the problem of drug abuse."*

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*Silcott, T. George, Executive Director, Wiltwyck School for Boys, Letter of Nov. 14, 1973.

APPENDIX

MEMORANDUM

AN ACT to amend the vehicle and traffic law, the penal law, the criminal procedure law and the mental hygiene law relating to the establishment of a New York State Driving Under the Influence of Alcohol Countermeasures Program.

Purpose of the Bill:

To create a New York state Driving Under the Influence of Alcohol Countermeasures Program to provide instructional, counseling, health and mental health services to persons convicted of alcohol-related traffic offenses, and others interested in taking advantage of such program.

Summary of the provisions of the Bill:

Bill section one amends the Vehicle and Traffic Law to provide an alternative to automatic revocation of the license of a person convicted of driving while his blood-alcohol content equals or exceeds .10 of one per centum by weight or while he is in an intoxicated condition. The alternative is participation in a Driving Under the Influence of Alcohol Countermeasures Program.

Bill section two incorporates two technical amendments necessitated by the addition of a new clause.

Bill section three requires the commissioner of motor vehicles, and other authorized persons, to suspend, rather than revoke, the license of a person convicted of such offenses provided the defendant participates in a Driving Under the Influence of Alcohol Countermeasures Program. The license of such person shall be suspended until he demonstrates a need to have it temporarily restored or, absent such a showing of need, until he has satisfactorily completed the program.

Bill section four provides that the commissioner of motor vehicles may not issue a new license or restore an old one to a person convicted of such offenses unless he participates in a Driving Under the Influence of Alcohol Countermeasures Program, either as a condition of probation or independently.

It also amends the subdivision to prohibit the reissuance or restoration of a license of a person twice convicted of driving while intoxicated or while his ability to do so was impaired by the use of a drug, when personal injury has resulted in the second, rather than in each, instance.

Bill section five directs the commissioner of motor vehicles, jointly with the commissioner of mental hygiene, to establish a Driving Under the Influence of Alcohol Countermeasures Program in each of the four judicial districts of the Supreme Court. It provides for the appointment of directors and the selection of program personnel, and requires that participation be open to the general public. The proposal specifies the requirements for satisfactory completion of the program and requires the director to make a written report to the court concerning completion of the program by persons whose participation has been imposed as a condition of adjournment in contemplation of dismissal or as a condition of probation. It provides that the suspension, revocation, or restoration of the license and certificates of registration of persons convicted of such offenses is to be conditioned upon their status in the program. Thus, the commissioner must revoke the license of a defendant who has not participated in the program and may not issue a new license or restore an old one until the defendant has so participated. The commissioner must suspend the license of a defendant who is participating in the program. However, he must restore such license upon satisfactory completion of the program and may restore it before satisfactory completion if the defendant makes a showing of need, such as the need to operate a motor vehicle to attend to his job or to participate in the program.

Bill section six repeals subdivision five of section eleven hundred ninety-two and enacts a new subdivision five which will control the disposition of persons convicted of violating the provisions of that section. The dispositions authorized for a person convicted of driving while his ability to do so was impaired by the use of alcohol remain unchanged.

A first offense of driving while blood-alcohol content equals or exceeds .10 of one per centum or of driving while in an intoxicated condition will remain an unclassified misdemeanor but will be punishable only by imprisonment for ninety days or by probation conditioned upon participation in a Driving Under the Influence of Alcohol Countermeasures Program. No alternative dispositions are authorized.

A second conviction of either of such offenses, within ten years, will remain a class E felony, which will be punishable only a) by a sentence of imprisonment, the minimum term of which has been increased from sixty to ninety days; or b) by a fine, the minimum amount of which has been increased from two hundred to five hundred dollars; or c) by both such fine and imprisonment; or d) by a period of probation conditioned upon participation in a Driving Under the Influence of Alcohol Countermeasures Program. No alternative dispositions are authorized.

A first conviction of driving while the ability to do so was impaired by the use of a drug remains an unclassified misdemeanor and the authorized dispositions remain unchanged. A second conviction of such offense, within ten years, remains a class E felony. However, the authorized minimum period of imprisonment will be increased from sixty to ninety days and the authorized minimum fine will be increased from two hundred to five hundred dollars.

Bill section seven incorporates a number of technical amendments necessitated by the addition of a new paragraph to subdivision three of section 65.00 of the penal law.

Bill section eight adds a new paragraph to subdivision three of section 65.00 of the penal law, to provide that the period of probation imposed upon a person convicted of an alcohol-related traffic offense shall terminate upon satisfactory completion of a Driving Under the Influence of Alcohol Countermeasures Program, and compliance with the other conditions of probation.

Bill section nine revokes the court's authority to impose a sentence of conditional discharge upon a person convicted of driving while his blood-alcohol content exceeds .10 of one per centum or of driving while in an intoxicated condition.

Bill section ten requires that a person convicted of such offenses participate in a Driving Under the Influence of Alcohol Countermeasures Program as a special condition of probation. It directs the sentencing court to notify the director of the imposition of such sentence.

Bill section eleven amends the criminal procedure law to provide that, when the court orders adjournment in contemplation of dismissal in such cases, it shall require, as a condition of such adjournment, that the defendant participate in a Driving Under the Influence of Alcohol Countermeasures Program. It directs the court to notify the director of such adjournment.

Bill section twelve amends section 9.03 of the mental hygiene law to direct the commissioner of mental hygiene to assist in the establishment of a Driving Under the Influence of Alcohol Countermeasures Program.

Justification of the Bill:

This proposal represents a recommendation of the Temporary State Commission to Evaluate the Drug Laws embodied and fully detailed in its report to the Governor and to the Legislature: Drug Abuse Prevention, Legislative Document No. 11, 1974.

The recommendation is that New York should adopt the Dade County (Florida) Driving Under the Influence of Alcohol Countermeasures Program, which has reduced drunken driving recidivism in Dade County from twenty percent to three percent. The Dade County model was based upon an earlier successful experiment in Phoenix, Arizona. It is now being expanded to encompass the entire state of Florida.

The thrust of the program is to force persons found to be driving while intoxicated to learn a great many specifics about alcohol, driving and themselves. For this reason, the recommendation is that both the commissioners of motor vehicles and mental hygiene, who have responsibility, respectively, for traffic safety and for alcoholism prevention and rehabilitation, establish the program.

The Temporary State Commission to Evaluate the Drug Laws has found that there is widespread public understanding and acceptance of the proposition that reliance on alcohol and irresponsible drinking constitute the most serious drug problem in the state. However, it is often true that only when vigorous law enforcement and extremely pointed rehabilitation demonstrate to an individual that he is in fact part of the problem can he actually learn to refrain from drinking irresponsibly in the context of operating a motor vehicle.

In some parts of the State, the current practice with regard to a variety of traffic offenses is to adjourn the action in contemplation of dismissal or to place the offender on probation. As a condition of such adjournment or probation, some defendants are required to participate in a Driver Rehabilitation Program, established pursuant to section 521 of the vehicle and traffic law.

In other parts of the State, participation in the Driver Rehabilitation Program is offered to individuals subsequent to their conviction and contemporaneously with the imposition of a fine. There are two types of courses offered: one for people with severe drinking problems and one for other offenders.

This bill would formalize, by statute, the participation of persons charged with or convicted of alcohol-related traffic offenses. It would expand the scope of the programs designed for drivers who are problem drinkers by permitting participation prior to conviction and, in some cases, prior to the filing of a misdemeanor information.

It would also open the program to the general public and, thus, with the additional revenue, be self-supporting.

In place of a fine, there is an across-the-board registration fee of $50.

Fiscal implications of the Bill:

The fact that the program is open to the general public and that a registration fee of $50 will be required of most participants should render the program self-supporting, as in Florida.

Effective date of the Bill:

September 1, 1975.

AN ACT to amend the vehicle and traffic law, the penal law, the criminal procedure law and the mental hygiene law relating to the establishment of a New York state Driving Under the Influence of Alcohol Countermeasures Program.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Clause (iii) of paragraph a of subdivision two of section five hundred ten of the vehicle and traffic law, such clause having been last amended by chapter two hundred seventy-five of the laws of nineteen hundred seventy, is hereby amended to read as follows:

(iii) of any violation of subdivisions two [,] or three [or four] of section eleven hundred ninety-two, unless such holder complies with the requirements of subdivision three of section five hundred twenty-four of this chapter, or of any violation of subdivision four of section eleven hundred ninety-two, section six hundred or section three hundred ninety-two or of a local law or ordinance making it unlawful to operate a motor vehicle while in an intoxicated condition, or to leave the scene of an accident without reporting, or an offense consisting of operating a motor vehicle while under the influence of intoxicating liquor or drugs where the conviction was had outside this state;

§2. Clauses (iv) and (v) of paragraph b of subdivision two of section five hundred ten of such law, such paragraph having been last amended by chapter one hundred fifty-six of the laws of nineteen hundred seventy-three, are hereby amended to read, respectively, as follows:

(iv) when the holder forfeits bail given upon being charged with any of the offenses mentioned in this subdivision, until the holder submits to the jurisdiction of the court in which he forfeited bail; [and]

(v) such certificates of registration shall be suspended when necessary to comply with subdivision eight of section sixty-three-y of the public service law [.]; and

§3. Paragraph b of subdivision two of section five hundred ten of such law, such paragraph having been last amended by chapter one hundred fifty-six of the laws of nineteen hundred seventy-three, is hereby amended by adding thereto a new clause, to be clause (vi), to read as follows:

(vi) when the holder is convicted of a violation of subdivisions two or three of section eleven hundred ninety-two, until such time as he has complied with the requirements of subdivision three or subdivision five of section five hundred twenty-four of this chapter.

§4. Subdivision six of section five hundred ten of such law, such subdivision having been last amended by chapter eleven hundred six of the laws of nineteen hundred seventy-one, is hereby amended to read as follows:

6. Restrictions. Where revocation is mandatory hereunder, no new license shall be issued for at least six months or, in certain cases, a longer period as specified in this chapter, after such revocation, nor thereafter, except in the discretion of the commissioner of motor vehicles [, and such]. The commissioner shall not issue a new license, nor restore the old, in any event, where a person has been convicted of a violation of subdivisions two or three of section eleven hundred ninety-two and has not participated in the Driving Under the Influence of Alcohol Countermeasures Program established pursuant to section five hundred twenty-four of this chapter and where a person has been twice convicted of driving a motor vehicle or motorcycle while intoxicated or while his ability to operate such motor vehicle is impaired by the use of a drug as defined in this chapter where personal injury has resulted from such driving while intoxicated or where such driving has been impaired by the use of a drug as defined in this chapter in [each] the second instance. Where revocation is mandatory hereunder, based upon a conviction had outside this state, no new license shall be issued until after sixty days from the date of such revocation, nor thereafter, except in the discretion of the commissioner. Where revocation is mandatory hereunder based upon a conviction of a person under the age of twenty-one years for operating a motor vehicle or motorcycle while in an intoxicated condition or while his ability to operate a motor vehicle is impaired by the use of a drug as defined in this chapter, no new license in any case where the issuance thereof or the restoral of the license revoked is not

prohibited shall be issued for at least six months after such revocation or until such person reaches the age of twenty-one years, whichever is the greater period of time, nor thereafter, except in the discretion of the commissioner. Where revocation is permissive, no new license or certificate shall be issued by such commissioner to any person until after thirty days from the date of such revocation, nor thereafter, except in the discretion of the commissioner after an investigation or upon a hearing, provided, however, that where the revocation is based upon a failure in a reexamination pursuant to subdivision eight of section five hundred one of this chapter, a learner's permit may be issued immediately and provided further, that where revocation is based upon a conviction of a felony, other than a felony relating to the operation of a motor vehicle or motorcycle, a license may be issued immediately, if the application for such license is accompanied by consent in writing issued by the parole or probation authority having jurisdiction over such applicant.

§5. The vehicle and traffic law is hereby amended by adding thereto a new section, to be section five hundred twenty-four, to read as follows:

§524. Driving under the influence of alcohol countermeasures program

1. The commissioner and the commissioner of mental hygiene shall, by joint regulation, cause to be established, in each judicial district of the Supreme Court, not later than September first nineteen hundred seventy-five, a program to be designated as

the New York state Driving Under the Influence of Alcohol Countermeasures Program. The director of such program in each judicial district and such assistants and such staff as may be necessary shall be appointed and may be removed by agreement of the commissioner and the commissioner of mental hygiene. Standards for qualifications of the personnel in the programs shall be established by agreement between the commissioner and the commissioner of mental hygiene.

2. Such programs shall be open:

(a) to participation by the general public;

(b) to participation by persons charged under subdivisions two or three of section eleven hundred ninety-two of this chapter, as a condition of an "adjournment in contemplation of dismissal" pursuant to section 170.55 of the criminal procedure law; and

(c) to participation by persons convicted of violations of subdivisions two or three of section eleven hundred ninety-two of this chapter and sentenced to a period of probation.

3. Satisfactory completion of the Driving Under the Influence of Alcohol Countermeasures Program shall be determined by:

(a) attendance in an abstinent condition at not less than thirteen hours of classroom instruction, or makeup sessions, in the case of unavoidable absence;

(b) completion of all in-class and homework assignments;

(c) utilization of counseling, health or mental health services, as may be reasonably required by the program directors; and

(d) unless otherwise ordered by the court, payment of a registration fee of fifty dollars.

4. Within sixty days after receipt of an order of the court requiring participation in such program as a condition of adjournment in contemplation of dismissal or as a condition of probation, the director of such program shall report to the court in writing concerning the satisfactory completion of the program by the defendant.

5. Notwithstanding any inconsistent provision of this chapter, the enforcement of any suspension order arising from a conviction of a violation of subdivisions two or three of section eleven hundred ninety-two may be stayed, provided that the defendant participates in the Driving Under the Influence of Alcohol Countermeasures Program and establishes a need to have his license and certificates of registration temporarily restored.

6. Notwithstanding any inconsistent provision of this chapter, the commissioner shall restore the license and certificates of registration of a person who has satisfactorily completed the Driving Under the Influence of Alcohol Countermeasures Programs.

7. The commissioner shall revoke the license and may revoke the certificates of registration of a person convicted of a violation of subdivisions two or three of section eleven hundred ninety-two of this chapter who has not satisfactorily completed the Driving Under the Influence of Alcohol Countermeasures Program. In such event, the commissioner shall not issue a new license, nor restore the old until the person has satisfactorily completed such program.

§6. Subdivision five of section eleven hundred ninety-two of such law, such subdivision having been added by chapter two hundred seventy-five of the laws of nineteen hundred seventy, is hereby repealed and a new subdivision, to be subdivision five, is inserted therein, in lieu thereof, to read as follows:

5.a. A first conviction of a violation of subdivisions two or three of this section shall be a misdemeanor and, notwithstanding any inconsistent provision of the penal law, shall be punishable only in the following manner:

(i) by imprisonment in a penitentiary or county jail for ninety days; or

(ii) by a period of probation pursuant to article sixty-five of the penal law.

b. A person who operates a vehicle in violation of subdivisions two or three of this section after having been convicted of a violation of subdivisions two or three of this section, or of driving while intoxicated, within the preceding ten years, shall be guilty of a felony and, notwithstanding any inconsistent provision of the penal law, any such violation shall be punishable only in the following manner:

(i) by imprisonment in a penitentiary or county jail for not less than ninety days nor more than two years; or

(ii) by a fine of not less than five hundred dollars nor more than two thousand dollars; or

(iii) by both such fine and imprisonment; or

(iv) by a period of probation pursuant to article sixty-five of the penal law.

c. When a sentence of probation is imposed pursuant to paragraphs a or b of this subdivision, the court shall require, as a condition thereof, that the defendant must participate in a Driving Under the Influence of Alcohol Countermeasures Program established pursuant to section five hundred twenty-four of this chapter. When a sentence of probation is imposed pursuant to paragraphs a or b of this subdivision, the period of probation shall terminate upon satisfactory completion of such program.

d. A violation of subdivision four of this section shall be a misdemeanor and shall be punishable by imprisonment in a penitentiary or county jail for not more than one year, or by a fine of not more than five hundred dollars, or by both such fine and imprisonment.

e. A person who operates a vehicle in violation of subdivision four of this section, after having been convicted of a violation of subdivision four of this section, or of driving while his ability is impaired by the use of drugs within the preceding ten years, shall be guilty of a felony, and any such violation shall be punishable by imprisonment for not less than ninety days nor more than two years, or by a fine of not less than five hundred dollars nor more than two thousand dollars, or by both such fine and imprisonment.

§7. Paragraphs (d) and (e) of subdivision three of section 65.00 of the penal law, paragraph (d) thereof having been amended by chapter six hundred seventy-six of the laws of nineteen hundred seventy-three, paragraph (e) thereof having been added by chapter six hundred seventy-six of the laws of nineteen hundred seventy-three, are hereby amended to read, respectively, as follows:

(d) Except as provided in [paragraph] paragraphs (e) and (f), for an unclassified misdemeanor, the period of probation shall be three years if the authorized sentence of imprisonment is in excess of three months, otherwise the period of probation shall be one year; [and]

(e) For a class B misdemeanor, or for an unclassified misdemeanor where the authorized sentence of imprisonment is not in excess of three months, if the defendant has been found to be a narcotic addict pursuant to section 81.21 of the mental hygiene law, the period of probation shall be three years [.]; and

§8. Subdivision three of section 65.00 of such law, such subdivision having been separately amended by chapters six hundred seventy-six and ten hundred fifty-one of the laws of nineteen hundred seventy-three, is hereby amended by adding thereto a new paragraph, to be paragraph (f), to read as follows:

(f) For an unclassified misdemeanor, where the sentence of probation is imposed pursuant to paragraphs a or b of subdivision five of section eleven hundred ninety-two of the vehicle and traffic law, the period of probation shall terminate upon satisfaction of the conditions thereof.

§9. Paragraph (a) of subdivision one of section 65.05 of such law, such subdivision having been added by chapter two hundred seventy-seven of the laws of nineteen hundred seventy-three, is hereby amended to read as follows: